Peter M. Levine, M.D., LLC
Use and Disclosure of Protected Health Information

SECTION I: PATIENT ACKNOWLEDGEMENT & CONSENT FORM

The educational pamphlet entitled "Notice of Privacy Practices" provides information about how Peter M. Levine, M.D., LLC, may use and disclose protected health information about you, and is compliant with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

My Notice of Private Practices states that I reserve the right to change terms described. Should this happen, I will display the new policy and effective date at my office.

You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations. I are not required to agree with your restrictions; but if I do, I am bound by our agreement with you.

By signing below, you acknowledge receipt of my Notice of Privacy Practices.

_____ _____
Patient's Signature Date

_____
Print Full Name

SECTION II: PERSONAL REPRESENTATIVE, FAMILY OR OTHER ENTITIES AUTHORIZED ACCESS TO PROTECTED HEALTH INFORMATION TO BE USED AND/OR DISCLOSED

Name or specifically identify the person and /or other entities you are authorizing to make use of and/or to disclose your protected health information regarding treatment, payment and other healthcare operations.

_____ _____ _____
Name of Authorized Person or Entity Relationship Phone

_____ _____ _____
Name of Authorized Person or Entity Relationship Phone

SECTION III: AUTHORIZATION FOR USE OF ANSWERING MACHINE AND/OR VOICE MAIL

This practice is routinely unable to contact patients directly during normal business hours. On these occasions, my office leaves messages on communication devices provided by my patients. Due to federally mandated HIPAA Privacy Rule, I must obtain your authorization to continue this mode of communication. Protected Health Information that I may possibly disclose on your home, work or cell phone would include, but is not limited to: test/lab results, prescription/pharmacy information, and appointment instructions.

_____ (Initial) Yes, I agree to allow Peter M. Levine, M.D., LLC, and staff to leave messages that include Protected Healthcare Information on <u>all three communication devices: home, work, cell</u>.

_____ (Initial) I agree to allow Peter M. Levine, M.D., LLC, and staff to leave message that include Protected Healthcare Information on the following:
Please initial next to the applicable communication devices:
_____ home number _____ work number OR _____ cell number

_____ (Initial) No, I do NOT agree to allow Peter M. Levine, M.D., LLC, and staff to leave messages that include Protected Healthcare Information on my home, work and cell phone.

_____ _____
Patient's Signature Date