RECEIPT OF HIPPA AND DISCLOSURE OF PATIENT INFORMATION

Disclosure of Patient Information:

Your medical information cannot be disclosed due to the HIPPA regulations unless you authorize this office to do so in writing. If you wish to grant access of your medical information to your spouse, partner, family member, or significant other, please name the person(s) on the line below.

Medical records and test results will not be given to anyone, unless the patient is present or has already been told/given the results of the test.

Please allow: (print name)_____to obtain my lab results (previously discussed with me) and disclosure of my financial records only.

Relationship to patient_____

Electronic Payment Processing:

Please sign below if you would like to have your credit card or debit card processed over the phone. This is for instances that you may want to pay a balance, lab costs, deposits,ect. We will never charge your card without your permission. In the event that we do not receive a signature, please be aware that any payments will need to be done through fax or in person.

Signature:_____

Receipt of HIPPA (Notice of Privacy Practices)

I acknowledge that I have read or received a copy of the attached Notice of Privacy Practices (HIPPA) and my questions regarding this policy have been answered and discussed by the office staff or Dr. Russel Williams.

Date:_____

Signature:_____ Printed Name:_____

Witness:_____ Date:_____