Patient Name: ____ DOB __________________________

MAB PULMONARY/SLEEP MEDICINE
Dr. S. Jerry Pinto
Holly Bell, ARNP-C

HIPAA RELEASE

I authorize Medical Associates of Brevard to discuss my health care information with:

____
(Name) (Relationship) (Phone #)

____
(Name) (Relationship) (Phone #)

Signed __________________________________ Date _____/____/____

I authorize Medical Associates of Brevard to leave a dated message on my answering machine.

Signed __________________________________ Date ____/____/____

Notice of Privacy Practices

I knowledge that I have received a copy of the Provider Notice of Privacy Practices for Medical Associated of Brevard. The Provider Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Provider Notice of Privacy Practices also describes my right and the responsibilities and duties of Medical Associate of Brevard with respect to my protected health information.

____
Name of Patient or Personal Representative

____
Signature Date

____
Name of Witness Date