MID-SUFFOLK MEDICAL CARE P.C

Mohammed Azaz, MD

Diplomate, American Board of Internal Medicine

INDEPENDENT PRACTICE --> WORKING ONLY FOR YOU.

6277, Jericho Turnpike Commack, NY 11725
Tel: (631) 462-6644 Fax: (631) 462-9890

3505 Veterans Hwy Ste B Ronkonkoma, NY 11779
Tel: (631) 467-3621 Fax: (631) 467-0017

PATIENT'S AUTHORIZATION

THIS FORM IS TO CONFIRM AUTHORIZATION TO USE/AND OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The law requires us to keep your medical information private.

I hereby consent to Island Medical Care to use and/or disclose my Protected Health Information (PHI) for the purposed of treatment, payment and health care operations.

Our Notice of Privacy Practices provides more detailed information about how we may use and/or disclose your health information. You have the right to review our Notice of Privacy Practices and can obtain a copy.

We reserve the right to change the terms of our Notice of Privacy Practices; provided that the change is permitted by the law.

I hereby give you permission to view my prescription information and history from all external sources. By signing this consent form you are agreeing that Island Medical Care can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefits payors for all treatment purposes.

You have the right to request us to restrict how we use and disclose your protected health information for the purpose of treatment, payment or health care operations.

You may revoke this consent at any time. Your revocation must be in writing, signed by you or on your behalf and delivered to the address on the form. You may deliver your revocation by any means you choose (e.g., persunally or by mail), but it will be effective only when actually received. Your revocation will not be effective to the extent that we or others have acted in reliance upon this consent.

Sign: _____ **Date:** _____

Patient's Name (Printed): _____

If you're signing as patient's representative:

Print Name: _____ **Relationship to Patient:** _____

I hereby authorize Island Medical Care to discuss my medical information with a member of my family.

Name: _____ **Relation:** _____

Phone Number: _____

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PATIENT RECORD OF DISCLOSURES

The HIPAA (Health Insurance Portability and Accountability Act) privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right ot request confidential communications or that acommunication of PHI be made by alternatives means, such as sending correspondence ni the individuals office instead of the individuals home.

I wish to be contacted in the following manner (check al that apply)

Home Phone: _____

( ) Okay to leave a message.

( ) Leave message with call-back number only

Cell Phone: _____

( ) Okay to leave message

( ) Leave message with call-back number only

( ) Okay to text message for quicker cal back responses

Work Phone: _____ **Ext:** _____

( ) Okay to leave message

( ) Leave message with call-back number only

Written Communications:

( ) Okay to mail to my house

( ) Okay to mail to my work/office address

( ) Okay to fax to this number **Fax:** _____

( ) Okay to email to this address **Email:** _____

Patient's Signature: _____ **Date:** _____

Patient Name (Printed): _____ **Birthdate:** _____