Dr. Shaik Ubaid

101 Jordan Road Ste 202

Troy NY 12180

P: (518)272-4601 F:(518)272-4600

Authorization of Release of Protected Health Information

Date:_____

Patient Name:_____DOB:_____

Please release medical records including consultation notes, ER reports, imaging, labs and office notes.

Signature of Patient or Representative:_____

Date:_____

Relationship to Patient or Representative:_____(if requestor is not the patient)

HIPAA Compliance Patient Consent Form

Our notice of Privacy provides information about how we may use or disclose protected health information.

The notice contains a patients rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the following information for treatment, payment, or healthcare operation.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

Protected health information may be disclosed or used for treatment, payment, or healthcare operations. The practice reserves the right to change the privacy policy as allowed by law.
The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
The practice has the right to revoke this consent in writing at any time and all full disclosures will then cease.
The practice may condition receipt of treatment upon execution of this consent.

May we discuss your medical condition with any member of your family? YES NO

If Yes, please name the members allowed:

_____

_____

This consent was signed by:_____

Signature:_____Date:_____

Emergency Contact:_____

Phone Number:_____