Authorization to Share Medical Information

Your Right to Medical Information Confidentiality

HIPAA is an acronym that stands for Health Insurance Portability and Accountability Act that was made into law in 1996. By law, if you are 18 years or older, you have the right to strict confidentiality regarding your visits with Dr. Kalikhman. In order to release any information including the date or nature of your visit, the practice has to have your signed consent and specific directions about what information you are consenting to be released. Without written consent, we cannot release or discuss any information relating to your visit with anyone including your parents, guardians, spouse, faculty, staff, or coach.

In addition, you have the right to revoke this authorization at any time. This will be effective when the practice receives your written revocation. A copy of this authorization will be kept in your health record maintained by Dr. Kalikhman and her staff. The information disclosed under this authorization might be re-disclosed by a recipient and may, as a result of this disclosure, no longer be protected to the same extent as this information was protected by law while solely in the possession of Dr. Kalikhman's medical practice.

Patient Name: _____
Date of Birth: _____

In signing this authorization to release my protected health information, I acknowledge that I have read and understand my rights to medical information confidentiality and authorize Dr. Kalikhman to discuss my health issues excluding all listed below:

_____
_____
_____

This information above can be discussed with the following individuals only:

_____ Relationship _____
_____ Relationship _____
_____ Date _____

Signature_____ Date_____