AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name:______________________ Date of Birth:____________ SSN# ____________________

Information Requested From:	Release Sent to:
John W. Royalty, DO, FACOS	Name:
3402 N. Lecanto Hwy Ste C	Phone:
Beverly Hills, Fl 34465	Fax:
352-563-5488	
352-563-6328 (fax)	

INFORMATION TO BE DISCLOSED (please specify):

Description	Dates (if available)	Description
☐ Admission History & Physical ☐ ER Reports ☐ X-Rays Reports ☐ Laboratory Reports ☐ EKG(s)/Ultrasound Reports ☐ Discharge Summary ☐ Consultation Reports		☐ Operative Reports ☐ X-Ray Films ☐ Other: ______________________ ______________________

PURPOSE OF DISCLOSURE (please specify):

☐ Continuing care with another physician or hospital ☐ Personal Copy ☐ Other: _________

AUTHORIZATION:

I understand that:

1. This authorization will remain in effect for one (1) year.
2. I may revoke this authorization at any time in writing, but if I do, it will not affect any actions taken prior to receiving the revocation.
3. I may refuse to sign this authoriztion and that it is strictly voluntary.
4. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
5. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
6. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
7. I will receive a copy of this form.

I acknowledge, and hereby consent to such, that the protected health information released may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. I also acknowledge I have read the above and authorize the disclosure of the protected health information as stated.

______________________________________ ______________

Patient/Guardian Signature Date

______________________________________ ______________

Patient/Guardian Name Printed Relationship

SEVEN RIVERS VASCULAR
John W. Royalty, D.O., F.A.C.O.S.
Board Certified Vascular and Thoracic Surgery
3402 N Lecanto Hwy, Suite C
Beverly Hills, FL 34465
PHONE: 352-563-5488 FAX: 352-563-6328 EMAIL: office@srvas.com

Notice of Privacy Practices Acknowledgment

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

____ ____________________
Patient Name or Legal Guardian (print) Date

____
Signature

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices:

Date:______________ Attempt:____

Staff Name:________________________________

SEVEN RIVERS VASCULAR

John W. Royalty, D.O., F.A.C.O.S.

Board Certified Vascular and Thoracic Surgery
3402 N Lecanto Hwy, Suite C
Beverly Hills, FL 34465
PHONE: 352-563-5488 FAX: 352-563-6328 EMAIL: office@srvas.com

PERSONAL PRIVACY NOTICE

Seven Rivers Vascular is committed to serve our patients with professionalism and caring, being sure at all time to protect the privacy and security of all protected health information.

During the course of serving your interests, we give you, our patient the opportunity to specify any person(s), i.e. spouse, family member, friend, or caretaker, with whom we may discuss your medical condition or your financial records with this practice.

Other than the reasons listed on our privacy practice notice, please be assured that we will not discuss your information with person(s) other than the ones you list on this sheet.

NAME:	RELATIONSHIP:
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

Patient Signature: ______________________________

Date: ____________________