LAMIA KADIR, M.D. PA

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HIPAA ACKNOWLEDGMENT/RELEASE FORM

Patient Name_____ Date of Birth_____

HIPAA ACKNOWLEDGMENT OF RECEIPT

I have been given the opportunity to read and receive a copy of Lamia Kadir, M.D. PA's Notice of Privacy Policy.

I understand that Lamia Kadir, M.D. PA will only use and/or disclose PHI (Protected Health Information) for treatment, payment or healthcare operations.

Signature_____ Date_____

RELEASE OF INFORMATION

- I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:
  - Spouse_____
  - Child(ren)_____
  - Other_____

- Information is not to be released to anyone

This release of information will remain in effect until terminated by me in writing.

MESSAGES

Please call my

{ }My Home Number { }My Cell Number { }My Work Number

If unable to reach me:

- You may leave a detailed message
- Leave a message asking me to return your call
- _____

Signature_____
Date_____