OFFICE OF PEGGY DEMETRIOU ARNP, FNP-BC

HIPAA Form

I. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment, and health care operation):

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II. Can confidential messages (i.e., appointment reminders) be left on your telephone answering machine or voicemail? YES________ NO__________

III. Effective Period:

This authorization for release of information covers the period of time that I am under the care of Peggy Demetriou ARNP and Qvita Health and Wellness.

IV. Extent of Authorization:

a. □ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

b. □ I authorize the release of my complete health record with the exception of the following information: □ Mental health records □ Communicable diseases (including HIV and AIDS) □ Alcohol/drug abuse treatment □ Other (please specify):

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V. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

VI. This authorization shall be in force and effect until I am subjected to switch physicians at which time this authorization expires.

VII. I understand that I have the right to revoke this authorization,in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

VIII. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

IX. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of patient or personal representative: ____

Printed name of patient or personal representative and his or her relationship to patient:

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Date: ___/___/_____