Michael Braden, MD, PA

Patient Name: _____ Date of Birth: _____ / _____ / _____

Notice of Privacy Practices

_____ *(Patient Initials)* I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations, and other described and permitted uses and disclosures. I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information and for the purposes described in the practice's Notice of Privacy Practices.

Release of Information

_____ *(Patient Initials*) I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: * Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly. * Obtain payment from designated third-party payers. * Conduct normal health care operations such as quality assessments or evaluations and physician certifications. I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand the organization is not required to agree to my requested restrictions, but if the organization does agree, then it is abound to abide by such restrictions. I understand that I may revoke this consent in writing at any time.

I authorize Michael Braden, MD, PA to contact me via the following methods: ***(Check all that apply)***

❒ Telephone ❒ Work phone ❒ Cell Phone ❒ Mail ❒ E-Mail ❒ Patient Portal

Disclosures to Friends and/or Family Members

I give permission for my Protected Health Information to be disclosed by phone, fax or in person for purposes of picking up prescriptions, communicating results, findings, and care decisions to the family members and others listed below:

Name	Relationship	Contact Number

**** This release will remain in effect until it is revoked in writing by the patient ****

_____ _____

Signature of Patient or Personal Representative **Date**