Richard S. York, M.D.

Patient Name_____ **Date of Birth**_____

This consent is in accordance with the HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA). Please list anyone with whom we have your permission to discuss your protected health information. *This should be people who need to know your condition (*spouse, children, guardian, care giver, friends, etc.).

Name:_____ **Name:**_____

Relationship:_____ **Relationship:**_____

Telephone:_____ **Telephone:**_____

Name:_____ **Name:**_____

Relationship:_____ **Relationship:**_____

Telephone:_____ **Telephone:**_____

Please list any *Facilities and Physicians* with whom we have your permission to discuss or release your protected health information (*primary care physician or other physicians involved on your care).*

Name:_____ **Name:**_____

Telephone:_____ **Telephone:**_____

Name:_____ **Name:**_____

Telephone:_____ **Telephone:**_____

I GIVE MY PERMISSION TO LEAVE A MESSAGE ON MY HOME ANSWERING MACHINE REGARDING AN APPOINTMENT TIME OR ASKING ME TO CALL THE OFFICE. I ALSO UNDERSTAND THAT I MAY REVOKE ANY PART OF THIS CONSENT AT ANY TIME WITH WRITTEN NOTICE TO THE PARTY MAKING THE DISCLOSURE.

Signature of Patient:_____ **Date:**_____

I HAVE RECEIVED A COPY OF THE PRIVACY PRACTICES FOR THIS OFFICE.

Name(print):_____ **Signature:**_____

Date:_____ **Witness:**_____