Dr. Kimberly Udell
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COMMUNICATIONS RELEASE

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY (HIPPA)

CONSENT FOR USE OR DISCLOSURE OF PATIENT INFORMATION FOR THE PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

Patient Name ____ Date of Birth________________________

SSN ____ Medical Record #____________________

CONSENT FOR LEAVING MEDICAL INFORMATION ON PERSONAL PHONE

By signing this section, I am consenting to have personal medical information left on my phone. The phone number, which I feel is secure enough for this information, is ____.

Patient Signature____ Date Signed______________________

COMMUINICATION WITH FAMILY AND OTHERS INVOLVED IN YOUR CARE

This section allows you, as the patient, to choose those persons you want to include and allow access to your medical information. This communication can be changed or voided by you at any time; however, we cannot retrieve information that has already been shared.

Please list any family members or others whom may be involved in coordinating your care. Also, please indicate the family member or other person's date of birth. If you are a dependent on your parents' insurance, please be aware that you must list your parent before we can release any billing/medical information to them for payment purposes.

Name (please print)	Relation to Patient	Date of Birth
________________________	______________________	________________________________
________________________	______________________	________________________________

When verifying identity over the phone it is our standard policy to ask questions regarding the patient's demographics (SS#, DOB, Address), or billing information. Please initial one of the following lines:

_ _ _ _ I approve of the standard identity verification process
_ _ _ _ I would like to use a password for identification purposes. Password: ___________________________

All the staff at Dr. Udell's office will continue to rely on the information on this form when communicating with family members or others unless you request a change. ***To alter or void the designation above, please send a written request to the address on the top of this form.***

Patient Signature _______________________________________ Date Signed ___________________________

I hereby consent to Kimberly Udell, D.O., P.A. (the "Practice") using or disclosing my protected health information for the purpose of providing treatment to me, obtaining payment for health care services rendered to me or to carry out the Practice's healthcare operations.

Patient Signature _________________________________Printed name of Patient/Representative___________________

Date Signed_____________________________________Relationship to Patient_______________________________