

PETER KIM, M.D.
JO SANTAMINA, M.D.

NEUROLOGY, NEUROPHYSIOLOGY

HIPPA law requires us to restrict release of patient information to any party due to patient confidentiality. Please fill out this paper to give us better idea who we can talk to.

Patient's Last Name _____ (First) _____ DOB: _____

HEALTH INFORMATION DISCLOSURE FORM

Is there a power of attorney? Yes No (if yes, please provide proof)

May we discuss your condition with anybody else? Yes No

If yes, please list the names and relationship to you.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I authorize Dr. Kim or Dr. Santamina and his office staff to discuss my condition with the person(s) I listed above.

Signature of Patient X _____ Date _____

PATIENT CONTACT INFORMATION

Home Phone Number: _____

May we leave a message about your appointment?

Yes No

May we leave a message about your condition?

Yes No

Work Phone Number: _____

May we leave a message about your appointment?

Yes No

May we leave a message about your condition?

Yes No

Cell Phone Number: _____

May we leave a message about your appointment?

Yes No

May we leave a message about your condition?

Yes No

Please list any other phone numbers we can call: _____

May we leave a message about your appointment?

Yes No

May we leave a message about your condition?

Yes No

I certify that the information in this document is true and correct. The authorization is valid unless and until it is revoked by me in writing

Signature of Patient X _____ Date _____

Acknowledgement of HIPAA Notice of Privacy Practice

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any questions to this form, please ask to speak with our HIPAA compliance officer in person or by phone at our main office number.

By signing this form, you acknowledge receipt of the HIPAA Notice of Privacy Practices for this office.

Name _____ Signature X _____ Date _____