

### Authorization for the Use and Disclosure of Individually Identifiable Health Information

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.

Please list the family members or other persons. If any, whom we may inform about your appointments, labs and x-rays results or other healthcare information. (PLEASE NOTE THAT THE FIRST PERSON LISTED SHOULD ALSO BE YOUR EMERGENCY CONTACT)

NAME	RELATIONSHIP	PHONE NUMBER
_____	_____	_____
_____	_____	_____
_____	_____	_____

Can confidential message including appointment reminders, labs and x-rays results or other health care information be left on your home answering machine or voicemail? (PLEASE CIRCLE ONE) YES NO

IF NO PLEASE PRINT THE TELEPHONE NUMBER, IF ANY WHERE YOU WANT TO RECEIVE THIS INFORMATION: \_\_\_\_\_

I understand that I may revoke or change this authorization at any time by notifying Charles J DePaolo, MD PA, in writing. I understand and agree that Charles J DePaolo, MD PA, HAS THIRTY (30) days from the date of receipt of the written revocation to update this information in the system.

However, the revocation will not be valid if:

1. Charles J DePaolo, MD PA has taken action in reliance on the above authorizations.
2. If this authorization is obtained as a condition for obtaining insurance coverage, other laws provide the insurer with the right to context a claim under the policy or the policy itself.

Patients Name: \_\_\_\_\_ Acct# \_\_\_\_\_

Signature of Patient/Authorized Representative \_\_\_\_\_ Date \_\_\_\_\_

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:** I have received a copy of the Notice of Privacy Practice for the above named practice. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by writing to the Privacy Officer, 3B McDowell St Asheville NC 28801 or by requesting one in person from the office at 3B McDowell St Asheville NC 28801.

Signature of Patient/Authorized Representative \_\_\_\_\_ Date \_\_\_\_\_

**\*\*\*\*\* FOR STAFF USE ONLY \*\*\*\*\***

Patient or Authorized Representative refused to sign after he/she received the Notice of Privacy Practices and was informed that signing the form merely acknowledges that the patient received the Notice.

An emergency existed and a signature was not possible at the time.

\_\_\_\_\_  
Name of Employee

\_\_\_\_\_  
Signature of Employee Date \_\_\_\_\_