Dr. Neal Bullock, D.P.M.

Dr. Adam Oxios, D.P.M.

17013 Pines Boulevard Pembroke Pines, FL 33027
Office:(954) 450-4200 Fax:(954) 450-4237

Patient's Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Email: _____

In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Dr. _____ will not release confidential health information, either in person or by telephone, email or fax to any unauthorized people. When returning telephone calls, we will not leave a message on an answering machine or voicemail unless we are authorized in writing to do so. Also, information will not be given to an unauthorized person who may answer your telephone (either at home or at work). If you would like to authorize us to release medical information to someone other than yourself or to leave information on a recording device, please complete the following:

I authorize Dr. _____ to release confidential medical information pertaining to my care by the following methods and to the following people. I understand that it is my responsibility to notify the office of Dr. Neal M Bullock DPM PA, if this authorization information changes.

It is okay to leave confidential medical information for me on my:

- ☐ Home Telephone answering machine/voicemail
- ☐ Work Telephone answering machine/voicemail
- ☐ Mobile Telephone answering machine/voicemail
- ☐ Email

It is okay to leave confidential medical information to my:

- ☐ Spouse
- ☐ Parent(s)
- ☐ Son/Daughter
- ☐ Brother/Sister
- ☐ Other (Name & Relationship required): _____

I authorize this information to be disclosed in the following ways:

- ☐ Written/Photocopy/Paper
- ☐ Verbal
- ☐ Facsimile

Dates of treatment: From: _____ To: _____

Specific description of the protected health information that I authorize for disclosure (Authorization to disclose psychotherapy notes must be separate):

- ☐ Progress Notes
- ☐ X-Ray films or other images
- ☐ Radiology Reports
- ☐ Discharge Summary
- ☐ Laboratory Reports
- ☐ Photographs/Video Tapes
- ☐ Operative Reports
- ☐ Records from other facilities
- ☐ Entire health records, (including, but not limited to information regarding medical/health treatment, insurance, demographics, referral documents and records from other facilities).
- ☐ Other: _____

I give specific authorization to disclose the following information:

- ☐ HIV test results
- ☐ Documentation of AIDS diagnosis
- ☐ Psychiatric/Mental health treatment records

Please indicate/describe each authorized purpose of the use or disclosure:

- ☐ At the request of the individual (patient)
- ☐ Other:

_____

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_____

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I have carefully read and understood the above, have had any questions explained to my satisfaction and do herein expressly and voluntarily authorize disclosure of the above information about, or medical records of, my condition to those persons or agencies listed above.

Patient's Signature: _____ Date: _____

Print Name: _____

When a patient is a minor or is not competent to give consent, the signature of a parent, guardian or other legal representative is required.

Signature of Legal Representative: _____ Date: _____

Print Name: _____