HIPAA Coversheet

Authorization to share health information:

I authorize the following to be apprised of my ongoing health status (circle or write in):

None/all family/father/mother/brother/sister/other _____

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_____

_____ signed _____ dated

I expressly authorize Dr. Miller and staff to discuss my condition with the following offices, doctors and their staff:

_____ _____

_____ _____

Contact Information

Contact me: ___ at any location or telephone number (we usually call work first)

___ at work _____

___ at home _____

___ by cell _____

___ by pager_____

___ e-mail _____

Mail to: ___ any location (we usually mail to home)

___ home _____

___ work _____

___ other _____

_____ signed _____ dated

I authorize the use of my picture, name and x-rays for in office displays of success stories and for health education purposes. No photograph, x-ray or name will ever be used outside the office or on a mailing list.

_____ signed _____ dated