# Elisabeth Potter, MD, PLLC

HIPAA Contact Information

Patient Name ________________________________________ Birth Date _____/_____/________

**I hereby authorize Elisabeth Potter, MD, PLLC to share the following information regarding:**

❑ **Demographics** (address, phone, insurance...) ❑ **Appointments** (dates, times, purposes...)

❑ **Medications** (prescriptions, dosage, pharmacy...) ❑ **Medical** (history, treatment, surgeries...)

❑ **Other** (specify) _________________________________________________________________

**with the following people:**

**Name** _____________________________________________ **Phone** (_______) _______-________

Relationship ❑ Spouse ❑ Parent ❑ Child ❑ Sibling ❑ Other _______________________

**Name** _____________________________________________ **Phone** (_______) _______-________

Relationship ❑ Spouse ❑ Parent ❑ Child ❑ Sibling ❑ Other _______________________

**Name** _____________________________________________ **Phone** (_______) _______-________

Relationship ❑ Spouse ❑ Parent ❑ Child ❑ Sibling ❑ Other _______________________

**for the duration of (unless revoked):**

❑ One Year ❑ Entirety of Care ❑ Date Range __________________ to __________________

I understand that:

- By signing, I am authorizing the release of private information which may include information protected under HIPAA regarding communicable diseases or mental illness
- If the receiving party is not subject to privacy laws, the information being released may not be protected and could be subject to an unauthorized disclosure, for which this provider and all of those associated with the practice would not be held liable
- If this authorization is revoked in writing, it will only apply to any future communication regarding my care and will not apply to any information that has already been released
- Authorizing the disclosure of this information is voluntary; I may refuse this authorization
- If I am signing on behalf of a patient that is a minor, the minor's signature is also required for the practice to share any information regarding:
  (1) conditions relating to the minor's sexuality (age 14 and above)
  (2) alcoholism and/or drug abuse (age 13 and above)
  (3) mental health conditions (age 13 and above)

Patient Signature ____________________________________________ Date ____________________

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