PAUL M POPPER, MD, PA

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

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I hereby authorize to release the named individual's health information as described below by Dr. Paul M Popper and his staff:

Patient Name _____ Date of Birth _____ Social Security Number _____

Address (street, city, state, zip code) _____ Telephone Number _____

This information may be released to the following individuals:

yes	no	
☐	☐	.....spouse:_____
☐	☐	.....child(ren):_____
☐	☐	.....caregiver:_____
☐	☐	.....other:_____

The following information may be released to those listed above:

yes	no		yes	no	
☐	☐	.... complete record	☐	☐	.... discuss treatment/medication
☐	☐	.... lab results	☐	☐	.... discuss payment/account information
☐	☐	.... x-ray reports	☐	☐	.... make/change appointments
☐	☐	.... scans	☐	☐	.... discuss mental/ behavioral information
☐	☐	.... cardiac studies	☐	☐	.... leave messages with
☐	☐	.... discuss contagious disease	☐	☐	.... leave detailed messages on answering machine
☐	☐	.... physician notes	☐	☐	.... pick up records
☐	☐	.... other_____			

I understand that any disclosure of information carries with it the potential for re-disclosure and that the information then may not be protected by the federal confidentiality rules.

I understand that I have the right to revoke this release authorization at any time. I understand that my revocation must be in writing. I understand that the revocation will not apply to information already released based on this released authorization.

I understand that authorizing the release of this health information is voluntary. I can refuse to sign this release. I do not need to sign this form to assure treatment. I understand that if this authorization is needed for participation in a research study, my enrollment in the research study may be denied.

I understand that I may inspect or obtain a copy of the information to be released.
Unless otherwise revoked, this authorization will expire one year from the date below.

_____ _____
Signature of patient or legal representative Date

If signed by legal representative, relationship to patient: _____

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