Hippa Compliance Patient Consent

PERRY
Medical Clinic

401 Northwood Drive, Centre, AL 35960

Phone: 256-927-3607 **Fax: 256-927-3605**

Patient:_____**Date of Birth:**_____

Any physician, staff, employee, or representative of Perry Medical Clinic, PC has my permission to discuss my medical record and account which may include; symptoms, treatments, diagnosis, test results, medications or any other type of protected health information with the following persons in order to facilitate and coordinate my care, treatment and payment:

Name	**Relationship**	**Phone Number**

I understand that authorizing the release of my information to the above individual(s) is voluntary and does not affect my access to treatment. I am allowed at any time to revoke this form by writing to Perry Medical Clinic, PC or by completing a new consent form. I can also, refuse to sign this form. This authorization will remain in effect until I change/revoke it. I understand that information shared with the above individual(s) may be subject to redisclosure by the individual(s).

Patient Signature:_____**Date:**_____