Medical Information Release Form
(HIPAA Release)

_____

Patient Name (Printed) Date of Birth

Email: _____

(by providing your email address you are consenting to Gillespie County Urology signing you up for our Patient Portal)

I authorize Michael C. Speck, M.D., P.A. to discuss and/or release my protected health information, including labs, test results, diagnosis and treatments discussed to the following persons:

Name	Relationship to Patient	Phone Number

☐ Do not release my information to anyone.

PHONE CALLS & MESSAGES

May we contact you **at home?** ☐ No ☐ Yes, the number is _____

May we contact you **on your cell phone?** ☐ No ☐ Yes, the number is _____

We will leave appointment reminder messages to your voicemail but will not leave detailed personal information.

Medicare Questions:

Advance Directive:

☐ I have an Advance Directive ☐ I do NOT have an Advance Directive ☐ Decline to Discuss

Name of Decision Maker: _____

Pneumococcal and Influenza Vaccine:

☐ I have ☐ I have NOT had the Pneumococcal Vaccine.

☐ I have ☐ I have NOT had the Influenza Immunization.

I acknowledge that Michael C. Speck, M.D., P.A. has made available to me a copy of the Notice of Privacy Practices (HIPAA). This notice describes how this office may use and disclose my protected health information. I understand that I can obtain a complete copy upon my request. A copy is also available at gillespiecountyurology.com

This release of information will remain in effect until terminated by the patient in writing.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date