Michael H. Polcino III, MD PLLC

HIPAA Authorization Form

Dr. Michael H. Polcino III, MD has taken measures to protect all of our patient's private medical information. We will not release any information to anyone unless you have provided the requested information below. These would be people other than what is covered in our Notice of Privacy Practices.

HIPAA (Health Insurance Privacy and Accountability Act) **does allow** us to release information to outside entities on your behalf. Examples of this are: another medical office when making you an appointment, your insurance company when trying to get your claims paid, your pharmacy or hospital.

Please check one of the following options:

☐ I ___________________________ **am authorizing** the person/people listed below to obtain medical information about myself. I understand that Dr. Michael H. Polcino, MD is not responsible for the information provided as long as it is given to a person that I have listed.

Date of Birth must be provided so that our office can verify that we are speaking to the correct person

1. Name: ____________________________________ Date of Birth: ____________________
2. Name: ____________________________________ Date of Birth: ____________________
3. Name: ____________________________________ Date of Birth: ____________________
4. Name: ____________________________________ Date of Birth: ____________________

☐ I ___________________________ **do not** authorize Dr. Michael H. Polcino III, MD to release any of my protected information to anyone other than the entities that are discussed in the Notice of Private Practices.

Patients Signature: ____________________________________ Date: _____________________