

HIPAA Authorization

141 Little East Neck Road
West Babylon, NY 11704
T: (631) 321-1045
F: (631) 321-1102



Dr. Michael H. Polcino has taken measures to protect all of our patients' 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 those covered in our Notice of Privacy Practices.

HIPAA (Health Insurance Privacy and Accountability Act) does allow us to release information to outside entities on our behalf. Example of this include another medical office when making an appointment, your insurance company when trying to get your claims paid, your pharmacy, and your 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 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, MD to release any of my protected information to anyone other than the entities that are discussed in the Notice of Privacy Practices.

Patient's Signature: _____ Date: _____