AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Patient_____ Date of Birth_____

DR. GREGORY P BIALEK is authorized to release protected health information about the above named patient in the following manner and to persons listed.

Information that may be communicated to you, authorized person/entity, other providers: Appointment reminders, Treatment, Financial,Breach

We may communicate to you via: **Circle all that apply**

Voice mail Text message E-Mail Answering Machine

E-mail communication-Provide email address*

E-mail:_____

In order for e-mail/text communication to occur, please accept & initial the disclosure below:

_____

____**Text/e-mail communication** I understand that if information is not sent in an encrypted manner, there is a risk it could be accessed inappropriately. It is my responsibility to update my email address. I still elect to move forward to allow email/text communication to occur.

Check each that can be given to person/entity listed below

____Treatment/Out of Pocket
____Appointment reminder
____Breach notification

Choose all that apply: ___Spouse ___Parent ___Step Parent ___Other, please specify_____

Provide name & phone number _____

Patient Rights:

- I have the right to revoke this authorization at any time
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

The information is released at the patient's request and this authorization will remain in effect until revoked by the patient.

_____Date_____

Signature of Patient or Personal Representative*

*Description of Personal Representative's Authority_____