Dr. Harvey Levy & Associates, P.C.
198 Thomas Johnson Drive, Suite 108, Frederick, MD 21702
Office: (301) 663-8300 Fax: (301) 682-3993 E-mail: appointments@drhlevyassoc.com

Communication Authorization

Patient's Name: _____ Date of Birth: ____/____/____
Last First MI

I, _____, (☐ Patient ☐ Parent/Guardian) give permission to

Dr. Harvey Levy and Associates, P.C. to discuss the following:

☐ Diagnosis, prognosis and/or treatment information

☐ Scheduling information

☐ Billing information

☐ Other (please specify): _____

with the following people:

_____ Relation: _____ Ph: (____)_____

_____ Relation: _____ Ph: (____)_____

_____ Relation: _____ Ph: (____)_____

I also authorize Dr. Harvey Levy and Associates, P.C. to:

☐ Leave messages on my cell voicemail

☐ Leave messages on my home answering machine

☐ Leave messages on my work answering machine/voicemail

☐ Send e-mails and/or text messages (may opt-out at any time after receiving initial e-mail or text)

☐ Leave messages with members of my household

Consent for Use and Disclosure of Health Information - HIPAA

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Lena Rotenberg
Telephone: (301) 663-8300 **Fax:** (301) 682-3993
E-mail: hipaa@drhlevyassoc.com
Address: 198 Thomas Johnson Drive, Suite 108, Frederick, MD 21702

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

_____(SEAL) _____

Patient/Parent/Guardian's Signature Date