ID on file □

Benjamin F. Asher, M.D.

IMPORTANT: HIPAA PRIVACY AND RECORDS RELEASE STATEMENT

Full Name: _____ ***Date of Birth:*** _____

HIPAA Privacy Statement:

Benjamin F. Asher M.D, P.C does not qualify as a covered entity under the provisions of the federal Health Insurance Portability and Accountability Act (HIPAA or PL104-191). However, we electively follow the mandated federal requirements of HIPAA in our handling and care of all personal-private health information.

Release of Information:

I authorize the release of any and all medical information to: my primary care physician; the referring practitioner; any and all practitioners I may be referred to; and any person(s) I legally designate.

I further authorize Dr. Asher's office to keep my signature on file for the purposes of insurance submissions, including assigning benefits directly to the office of Benjamin F. Asher, MD, PC when appropriate – and to release any and all medical or other information to my insurance / health plan administrator required to process your claim.

Please choose ONE option below.

□ **I have read and AGREE to the above. I will provide written notice in the event that I want to change the information on file.**

OR

□ **I have read and *DO NOT* agree to release my medical information to referring providers. I will sign a Release of Information form each time that I want my medical records released.**

Signed: _____

Date: _____ Witness: _____

For annual signature renewal only:

Signed: _____

Date: _____ Witness: _____

Signed: _____

Date: _____ Witness: _____