



**FLORIDA HOSPITAL**

*Memorial Medical Center*

*HealthCare Partners*

**Julie Schneider, MD**

**Florida Hospital Memorial Medical Center**

**Patient Notice**

(Request For Limitations and Restrictions of PHI)

**HIPAA** (Health Insurance Portability & Accountability Act of 1966; a federal law) requires healthcare organizations to comply with specific rules (Notice of Privacy Practices) regarding your **Protected Health Information (PHI)**.

With my consent the office of Dr. Julie Schneider, MD/Florida Hospital Memorial Medical Center may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to Florida Hospital Memorial Medical Center Notice of Privacy Practices for a more complete description of such uses and disclosures. **Please note: The practice is not required to agree to your request. Please see Notice of Privacy Practices for more information regarding such requests.**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

I authorize Dr. Schneider's office to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes.

***Please check Yes or No and Write Telephone Number(s)***

Home Telephone  Yes  No Number: \_\_\_\_\_

Home Voice Mail  Yes  No

Work Telephone  Yes  No Number: \_\_\_\_\_

Work Voice Mail  Yes  No

Cell Phone  Yes  No Number: \_\_\_\_\_

Cell Phone Voice Mail  Yes  No

Email  Yes  No Address: \_\_\_\_\_

**We will try to honor your above request. However, if you DO NOT give us a telephone number, we will not be able to contact you with results. Please be aware, certain results will require an appointment to discuss your results, whether normal or abnormal.**

Please list names of people, including physicians, we can discuss your medical care with and/or give records to:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Physician: \_\_\_\_\_ Physician: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient/Parent/Legal Guardian