



FLORIDA HOSPITAL

Memorial Medical Center

HealthCare Partners

Dr. Julie Schneider, MD

Florida Hospital Memorial Medical Center

Patient Notice

(Request For Limitations and Restrictions of PHI)

HIPPA (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 (H) Yes No Number: _____

Answering Machine Home (HAM) Yes No

Work Telephone (W) Yes No Number: _____

Voice Mail (work) (VM) Yes No Number: _____

Cell Phone (C) Yes No Number: _____

Cell Phone Voice Mail (CVM) Yes No

Pager (P) Yes No Number: _____

Email (E) 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 your lab results. Therefore, you will have to reschedule an office visit appointment to discuss your results, whether normal or abnormal.

Please list names of people **we can discuss** your medical care with or give records to:

Spouse: _____ Parent: _____

Other (Name): _____ Relationship: _____

Physician: _____ Physician: _____

Signature: _____ Date: _____

Patient/Parent/Legal Guardian