Anthony Baldizzi, MD

1752 2nd Ave. N, St. Petersburg, FL 33701

HIPPA PRIVACY AUTHORIZATION FORM

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act -- 45 CFR Parts 160 and 164)

This form should be used by the patient to authorize release of PHI to a patient's immediate family member, other relative, or a close friend of the patient, or any other person to whom the patient has given authorization.

PATIENT NAME: _____

DATE OF BIRTH: _____ / _____ / _____

PERSON(S) WHO SHOULD HAVE ACCESS TO PERSONAL HEALTH INFORMATION:

(The person who as access must be able to verify three information items verbally, i.e. patient social security number, patient date of birth, and street address)

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to Protected Health Information. If you have objections to this form, please ask to speak with our HIPAA Privacy officer in person or by phone at our main number, 727-623-9100.

Due to HIPAA Privacy Practices, we need to separate authorization to leave messages for our patient:

I hereby agree to allow Anthony Baldizzi, MD to leave messages on my listed phone contact.

☐ Yes ☐ No

Anthony Baldizzi, MD will follow HIPAA Privacy Practices when discussing your medical or billing information unless otherwise indicated with written request for a restriction of you Protected Health Information.

Date ____ / ____ / _____

Printed Name: _____

Signature: _____

Relationship to patient if patient is a minor:

_____

_____

_____