Patient Consent for Disclosure of Protected Health Information
Neil S. Heskel, M.D.

I hereby give my consent for Dr. Neil S. Heskel to use and disclose protected health information about me to carry out treatment, payment and healthcare operations.

Name_____

Mailing Address_____

City _____State _____Zip Code_____

Telephone (____)_____Work Phone(____)_____

Date of Birth _____Name of Insurance_____

With this consent, Dr. Neil Heskel's office may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in my clinical care, including appointment reminders, insurance items, and laboratory results.

With this consent Dr. Neil Heskel may mail to my home or other alternative location any items that assist the practice in my clinical care, including appointment reminders, insurance items, and laboratory results.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. Such refusal will not affect your ability to obtain treatment except to the extent that the information being requested may assist your healthcare provider in determining appropriate treatment. Your refusal to sign this authorization will not affect your ability for benefits.

PLEASE NOTE: Unless otherwise specified by law, we will release only that information which has been created by our employees or agents, including chart notes, lab results, summaries, and consultation reports. Records created by and available from other providers, hospitals, or other care facilities must be obtained directly from those other providers or facilities.

Signature _____ Date _____

If this authorization is signed by an individual's personal representative on behalf of the individual, please complete the following:

Personal Representative's Name _____

Contact Information (Phone#)_____

Relationship to the Patient _____

I hereby authorize Dr. Neil Heskel to discuss my medical care with:

_____ _____

Name **Relationship to patient**

_____ _____

Name **Relationship to patient**