

East End Plastic Surgery & Laser Center

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**Persnal Health Information (HIPAA) Release**

Patient confidentiality is one of our staff's primary priorities. In order to ensure that no one on our staff releases confidential information to unapproved parties, please fill out the section below. Only the people listed below will be apprised of your case history and progress. You may choose two people (such as a spouse or child). If you would like to alter this information you must make us aware of the change **IN WRITING**. Should you decide not to allow anyone access to information regarding your records, please indicate this below. Thank you for your cooperation in matter.

Patient Name: \_\_\_\_\_ (Please complete information below)

**PLEASE SIGN THIS FORM IN ONLY ONE PLACE**

The primary person that I wish to have access to my private health information is:

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

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

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

Telephone #: \_\_\_\_\_ Alternate Phone# \_\_\_\_\_

The second/alternative person that I wish to have access to my private health information is:

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

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

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

Telephone #: \_\_\_\_\_ Alternate Phone# \_\_\_\_\_

\_\_\_\_\_  
*Patient/Parent/Guardian Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Witness Signature*

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**If you choose not to authorize the release any information to anyone other than yourself, please sign your name below. I have read and understood the above information. DO NOT SIGN HERE IF YOU'VE FILLED IN THE INFORMATION ABOVE.**

\_\_\_\_\_  
*Patient/Parent/Guardian Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Witness Signature*

**\* PLEASE BE AWARE THAT THIS AUTHORIZATION CAN ONLY BE CHANGED IN WRITING\***