HIPAA Release of Medical Information

Persila V. Mertz, M.D., P.C.
115 East Main Street
Ephrata, Pa 17522
717-733-3600

Name: _____ **Date of Birth:** _____/_____/_____

1. I authorize the release of information including diagnosis, records and insurance claims information. This information may be released to:
   - Spouse_____
   - Child(ren)_____
   - Other_____
   - **I do not authorize my information to be released to anyone.**

This ***Release of Information*** will remain in effect until terminated by me in writing.

2. Please call me at:
   - My home_____
   - My cell number_____
   - My work number_____

   If unable to reach me:
   - You may leave a detailed message
   - Please leave a message asking me to return your call
   - _____

3. I acknowledge that I have been made aware that a copy of the Privacy Practices of Persila V. Mertz, M.D., P.C. is available upon request.

Signature of Patient, or Parent/Guardian:_____ Date:__/__/____

Staff:_____ Date:__/__/____