

PCA – Primary Care Associates, P.A.

**HIPAA / RELEASE OF INFORMATION PER PATIENT’S ASSIGNMENT**

I have acknowledged/received a written copy of PCA’s “Notice of Privacy Practices” and I (patients name) \_\_\_\_\_ (DOB) \_\_\_\_ / \_\_\_\_ / \_\_\_\_, authorize any physician/staff employee of PCA- Primary Care Associates, P.A. to engage in any verbal or written communication to any/all persons listed below regarding my medical history/ care/ records/ appointments and/or information pertaining to my personal account/billing history with PCA- Primary Care Associates, P.A.

Name:

Relationship:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**VOICEMAIL / ANSWERING MACHINE**

I authorize any physician/staff employee of PCA – Primary Care Associates, P.A. to leave health information on a voicemail/answering machine at the following numbers:

Phone #:

Location (home, work, etc.)

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**PATIENT UNDER AGE**

If patient is a minor (person below age of 18), please list any other person(s) over the age of 18 that is allowed to bring child to office visits and/or labs. If child is brought to office visit by a person not listed below, notarized consent by parent/guardian must be provided at date of visit along with a picture ID.

Name:

Relationship:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

-----  
\_\_\_\_\_ Initial here if you **DO NOT** authorize assignment of any person(s) to communicate with PCA-Primary Care Associates, P.A, for any reason, including your emergency contact.  
-----

I understand that this authorization may be revoked or modified at any time on submission of my written request or that of my representative.

Patient / Representative: X \_\_\_\_\_ Date \_\_\_\_\_

Relationship (if other than patient) \_\_\_\_\_

**A COPY OF THIS DOCUMENT IS VALID AS AN ORIGINAL**