ISSAM A. HALABY, MD
GENERAL & VASCULAR SURGERY

436 Nokomis Avenue South · Venice, FL 34285 · Office 941-445-5054 · Fax 941-303-6796

Disclosure of Confidential Information (H.I.P.A.A.)

Patient Name _____ DOB _____ /_____ / _____

In response to the Health Insurance Portability and Accountability Act, Surgical Associates of Venice & Englewood would like permission to disclose your confidential information and request that the following determinations are made which give us guidelines as to who you would like to have access to your confidential information.

Please place an X on the line(s) beside each name to advise as to what information we are permitted to share with each individual. If you list a name but no designation, we will assume that any/all types of information may be shared. We do NOT need the names of your physicians or Healthcare facilities, ONLY the names of your family and/or friends.

Name(s)	Appointment	Financial	Medical	ALL
_____	____	____	____	____
_____	____	____	____	____
_____	____	____	____	____
_____	____	____	____	____

I understand that the only way to change the permissions given above is to complete and sign a subsequent form. In addition, I agree that Surgical Associates of Venice & Englewood may leave appointment information with others who answer my preferred method of contact, on my answering machine or cell phone.

Patient Signature _____ Date _____

I consent to receiving emails, texts (SMS), auto-dialed and or artificial or pre-recorded messages to my cellular phone or to telephone numbers or email provided by me to Surgical Associates of Venice & Englewood or their agents including, without limitation, any account management companies and independent contractors including debt collectors. I understand that consenting to the above is not required before I receive service.

Patient Signature _____ Date _____