Newport Pulmonary and Endocrine Associates
520 Superior Ave #390, Newport Beach, CA 92663
949-548-3177

Acknowledgement of Notice of Privacy Practices

By signing this form you acknowledge you were advised of the Notice of Privacy Practices for Newport Pulmonary and Endocrine Associates. Our Notice of Privacy Practices provides information about how we may use and disclose your protected information. We encourage you to read it in full. Our Notice of Privacy Practices is subject to change. The Notice of Privacy is available on our website at www.pulmonaryendocrine.com and in our office. You may request a copy of the Notice of Privacy.

____________________________________ _________________
Signature of Patient /Patient Representative Date

____ ____________________
Name of Patient/ Patient Representative (please print) Relationship to Patient

Authorization for Disclosure of Medical Information

Patient Name:

____
Last First MI Other Name

Date of Birth: ____-_____-_____ Phone: ______________________

Address: _________________________City:___________________ST:_______Zip:_________

I authorize disclosure of my protected health information to the following:

NAME: ______________________________ RELATIONSHIP: ______________________

NAME: ______________________________ RELATIONSHIP: ______________________

NAME: ______________________________ RELATIONSHIP: ______________________

This authorization shall remain in effect until it is revoked by a request in writing.

You have the right to receive a copy of this authorization.

____ ___________
SIGNATURE OF PATIENT DATE

____ ____________
PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON DATE