Steven M. Rosman, DC, PhD
5243 Lake Village Drive
Sarasota, FL 34235

As a result of the Health Insurance Portability and Accountability Act (HIPAA), enforced by the US Department of Health and Human Services office of Civil Rights, the Office of the Inspector General, OSHA, and HCFA, we are not permitted to release patient information except as stated in the Notice of Privacy Practices or in accordance with your wishes as stated below.

This waiver authorizes Dr. Steven M. Rosman to send/give my clinical information as noted:

Leave a voice mail recording on my home/cell phone Yes_____ No _____
Leave a voice mail recording on my business phone Yes_____ No_____

Speak to a family member of my choosing: _____ Yes _____ No _____

Information may be mailed to my home Yes _____ No _____

Speak with the medical professionals who provide care and medical supervision for me.

No _____ Yes _____

If yes, I authorize Dr. Rosman to speak with any of the following medical professionals and request my records from them:

_____

_____

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On this date _____ I received and reviewed this Notice of Privacy Practices which describes how my medical information may be used and disclosed and explains how I can gain access to this information.

I had an opportunity to raise questions regarding this policy and all of my questions have been answered.

I understand and agree to allow Dr. Rosman to use their Patient Health Information for the sole purpose of treatment, payment, healthcare operations and coordination of care. If I have any questions as to how my Patient Health Information is going to be used and my rights concerning these records I have been informed to ask Dr. Rosman. If there is anyone I do not want to receive my medical records I will disclose that information to Dr. Rosman..

This will remain effective until such time as I notify Dr. Steven M. Rosman in writing by certified mail.

_____ _____

Patient Signature Date

_____ _____

Social Security Number Date of Birth