Please complete this form online.
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You can fax it or bring it with you
to your appointment.

Paul E. Hammerschlag, MD, FACS

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This is to certify that I have read and understand the HIPAA information provided to me by Paul E. Hammerschlag, MD, FACS regarding office privacy policies. I was offered the opportunity to take home a copy if I desire to do so.

Sign:____

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Date:____

I hereby give permission for you to provide the below listed people with medical information regarding my diagnosis, treatment and care, to the same extent that you would give to me directly.

1. ____

2. ____

3. ____

NAME: _______________________________________ DATE: _______________

I hereby give permission for you to fax me, or any other person/place that I might designate, copies of my results or medical records.

NAME: ______________________________________ DATE: ______________________