Antonios J. Tsompanidis, D.O.
A PROFESSIONAL CORPORATION

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# PATIENT INFORMATION RELEASE

In accordance with the new Federal and HIPAA (Health Insurance Portability and Accountability Act) regulations, any medical information pertaining to you will only be disclosed to the person(s) indicated below. If they are not listed below, no information will be disclosed at any time. Any changes to patient release information must be in writing. If you have questions regarding this form, please ask the staff or the physicians. Thank you for your cooperation and understanding.

Date:___________________ 20____

This is to certify that I,

(Print Name)______________________________________________________________________

authorize the office of Antonios Tsompanidis DO PC to disclose any medical information to the following person(s) only:

| NAME | RELATIONSHIP |
| --- | --- |
| ____________________________________________ | ___________________ |
| ____________________________________________ | ___________________ |
| ____________________________________________ | ___________________ |
| ____________________________________________ | ___________________ |

**OR**

___________ (Please initial) **I DO NOT WISH** to have any of my health related information released to anyone other than myself.

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___________ (Please initial) I have received and read the condensed version of this office's privacy act.

Signature: ____________________________________________________________________________