JONATHAN T. PAINE, M.D .. F.A.C.S.
NEUROSURGERY

1305 South Valentine
Street Melbourne. FL
32901
Telephone (321) 727-2468
Fax (321) 952·0163

HIPAA CONTACT INFORMATION FORM

In order to assist you in receiving your health information from Jonathan T. Paine M.D., P.A., please complete this form:

_____ (Initial) Jonathan T. Paine M.D., P.A. is permitted to share **any and all** medical information with the following individuals listed below, including test results, sensitive information as stipulated by the State of Florida, and information disclosed during office visits.

_____ (Initial) Jonathan T. Paine M.D., P.A. is permitted to share **any** medical information with the individuals listed below, including test results, sensitive information as stipulated by the State of Florida, and information disclosed during office visits.

Except: _____

Persons authorized to receive my medical information:
(Include: Full name, relationship, and phone number.)

NAME: **RELATIONSHIP:** **PHONE NUMBER:**

_____
_____
_____
_____

You may notify me with test results, appointment reminders and other information regarding my health information as follows:

___ Message on answering machine (Phone # _____)

___ Message on work voicemail (Phone # _____)

___ Message on cell phone (Phone # _____)

___ Email Address _____

I understand and direct that this authorization will remain in effect until it is revoked by me in writing.

_____ _____
Printed Name Signature

DOB:_____ Date:_____

This authorization is **not** valid for the request of printed copies of your medical records. You and only you (or your legal personal representative) must sign a Health information Release form to obtain copies of your medical records.