DAWN BRODERICK, M. D. LLC
18111 PRINCE PHILIP DRIVE
SUITE 201
OLNEY, MD 20832

Privacy practice Acknowledgement

HIPAA Authorization Form

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information (PHI). By signing this authorization, I permit Dawn Broderick, M.D. to use and/or disclose individually identifiable health information (PHI) about my medical history, lab results and outcomes of any therapies provided only under the following conditions:

- with my permission or at my (the patient's) request.
- the purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information.
- the Practice will not receive payment or other remuneration from a third party in exchange for using or disclosing information without my consent or participation.

VOICE MAIL MESSAGES: Please initial in the space provided next to each of the following permissions **if you are in agreement**:

I give the Practice permission to leave a medical message on my:

_____ Mobile voice mail Phone: _____

_____ Home voice mail Phone: _____

_____ Work voice mail Phone: _____

If I cannot be reached directly or by voice mail, the Practice may leave a message with my:

_____ Spouse Name: _____ Phone: _____

_____ Parent Name: _____ Phone: _____

_____ Other Name: _____ Phone: _____

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EMAIL COMMUNICATION: Our practice utilizes an encrypted HIPPA compliant secure email vendor. Email is primarily used to reply to questions or send announcements. However, on occasion, we will send PHI via email. Further, if you elect to communicate from your workplace computer or use your work email, you should be aware that your employer has the right to access your email communications.

Please check your preference below.

☐ I do not want to receive email communication

☐ I consent to receive email communication as described above.
Print email address (if the patient is a minor, please list the email address of the parent or guardian):
_____@_____

TEXT MESSAGES: The practice may use text messaging for reminders and to communicate health information.

Please check your preference below.

☐ I do not want to receive text messages

☐ I consent to text messages Mobile Number: _____

_____

I do not have to sign this authorization in order to receive treatment from Dawn Broderick, M.D. LLC. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subjected to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at:

Dawn Broderick, M.D. LLC
18111 Prince Philip Drive, Suite 201
Olney, MD 20832

Signed by: _____ _____
Signature of Patient or Legal Guardian Relationship to Patient

_____ _____
Print Patient's Name Date

_____
Print Legal Guardian's Name, if applicable