REQUEST FOR SPECIAL PRIVACY PROTECTIONS
DARYL MARX, MD

AS REQUIRED BY THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996, YOU HAVE A RIGHT TO REQUEST THAT WE RESTRICT OUR USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION WITH RESPECT TO TREATMENT, PAYMENT AND HEALTH CARE OPERATION. YOU ALSO HAVE A RIGHT TO REQUEST THAT WE RESTRICT OUR USES AND DISCLOSURES OF YOUR HEALTH INFORMATION WITH RESPECT TO DISCLOSURES TO MEMBERS OF YOUR FAMILY AND OTHER RELATIVES OR CLOSE PERSONAL FRIENDS OR OTHER PERSONS YOU IDENTIFY WHO ARE INVOLVED IN YOUR CARE OR PAYMENT FOR YOUR CARE, OR TO NOTIFY OR ASSIST IN NOTIFYING THOSE INDIVIDUALS OF YOUR LOCATION, GENERAL CONDITION, OR DEATH. THIS MEDICAL PRACTICE DOES NOT HAVE TO AGREE TO YOUR REQUEST, BUT IF WE DO WE WILL ABIDE BY OUR AGREEMENT UNTIL EITHER OF US TERMINATES THE AGREEMENT.

_____ I ALLOW DR. MARX AND HIS OFFICE STAFF TO DISCLOSE MY HEALTH INFORMATION AT HIS/THEIR DISCRETION TO WHOM THEY SEE FIT (ACCORDING TO HIPPA REGULATIONS).

_____I DO NOT WANT MY HEALTH INFORMATION TO BE DISCUSSED WITH OR RELEASED TO ANYONE OTHER THAN MYSELF AND/OR PLACE RESTRICTIONS ON ITS USES AND DISCLOSURES. (PLEASE REQUEST A FORM FROM THIS OFFICE TO APPLY RESTRICTIONS.)

_____ YOU MAY RELEASE AND / OR DISCUSS MY HEALTH INFORMATION WITH THE FOLLOWING PERSON/PERSONS.

A. _____

B. _____

C. _____

D. _____

SIGNATURE _____ DATE _____

_____ PARENT/GUARDIAN

_____ OTHER (SPECIFY) _____

*BY LAW, THIS RESTRICTION WILL NOT APPLY WITH RESPECT TO INFORMATION NECESSARY TO PROVIDE EMERGENCY TREATMENT, FOR USES OR DISCLOSURE REQUIRED BY LAW, OR FOR CERTAIN PUBLIC HEALTH ACTIVITIES, JUDICIAL AND ADMINISTRATIVE PROCEEDINGS, LAW ENFORCEMENT PURPOSES, CORONER INVESTIGATIONS, ORGAN OR TISSUE DONATIONS, RESEARCH ACTIVITIES, SPECIALIZED GOVERNMENT FUNCTIONS OR WORKERS COMPENSATION ACTIVITIES.

DARYL S. MARX MD, LLC

2301 JUSTICE ST., MONROE, LA. 71201 PH: 318-398-9709 Fax: 318-398-9711

RELEASE OF INFORMATION

Patient's Name: _____

Patient's SS#: _____ DOB: _____

Address: _____
Street City State Zip

Provider Authorization to Release the Health Information (The Provider)	Name of Physician releasing the information:
Entity to receive the Health Information (The "Recipient):	Name of the Physician/Facility receiving the information:
Recipient's Address:	Street City State Zip Attention: Dept:

Health information that is covered by this authorization:

- ☐ Complete Health Record
- ☐ Discharge Summary
- ☐ History & Physical Examination
- ☐ Consultation Reports
- ☐ Other (Please Specify): _____
- ☐ Progress Notes
- ☐ Laboratory Tests
- ☐ X-ray Reports

Purpose of Disclosure: _____

Patient's Signature: _____

The patient (or personal representative on behalf of the patient) herby authorizes the Provider named above to release the Health information described above to the Recipient named above. The patient has the right to refuse to sign this authorization.

This authorization to release the health information listed above can be revoked at any time (upon written notification) except to the extent that (1) Provider has already released the health information before being notified of the revocation, or (2) Provider has taken action in reliance on this authorization. Provider's Notice of Privacy Practices contains more information on how to revoke this authorization.