

**SISSELMAN MEDICAL GROUP, PC**

100 Veterans Boulevard, Suite 2 Tel: (516) 308-4040  
Massapequa, NY 11758 Fax: (516) 804-6386

2171 Jericho Turnpike, Suite 135 Tel: (631) 670-6525  
Commack, NY 11725 Fax: (631) 670-6526

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Please fill out either section I OR section II and sign below:

**Section I:**

A. I, \_\_\_\_\_ give Sisselman Medical Group, PC, permission to leave information on my answering machine or with the following family member(s) or designated representative(s) as noted below:

Answering Machine(s) at the following number(s): \_\_\_\_\_

Family Member(s) or designated representative(s) (Please print full name and relationship)

\_\_\_\_\_  
\_\_\_\_\_

B. Please check all information that can be left on the above answering machine(s) or with the above representative(s):

- Test Results
- Lab Results
- Confirming Appointments
- Medication Chnages
- Billing/Insurance Changes
- Any information pertaining to all aspects of my medical care, including all of the above.

**Section II:**

I, \_\_\_\_\_, do not want any information pertaining to all aspects of my medical care left on my answering machine or with anyone other than myself.

I understand that: 1. I may revoke/amend this authorization at any time, provided that the revocation/amendment is in writing. 2. information disclosed in coordinance with this authorization may be redisclosed by the recipient and no longer protected by HIPPA privacy rules. 3. this practice will not condition treatment on my providing the above authorization. 4. I have the right to access my protected health information.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

Relationship to patient (if minor, or signed by personal representative): \_\_\_\_\_

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

I have received this practice's Notice of Privacy Practices, which provides in detail the uses and disclosures of my protected health information that may be made by this practice, my rights and the practices legal duties with respect to my protected health information. I have been provided to review the Notice of Privacy Practices and understand that I can obtain a copy on request.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to patient (if minor, or signed by personal representative): \_\_\_\_\_