INTERNAL MEDICINE PHYSICIANS ASSOCIATES, P.C.
FRANK A. AGNONE, M.D.
ANN LACEY, MSN, FNP-C
STEPHANIE NIEPOKOJ-DUNN, MSN, FNP-C

Patient Name: _____

Date of Birth: _____

HIPPA ACKNOWLEDGEMENT

I hereby authorize Internal Medicine Physicians Associates to release protected health information to the individuals listed below. I understand that I may revoke this authorization at any time giving written notification to this office.

These people may receive my Protected Health Information:

Name: _____ Date of Birth: _____

Relationship to Patient: ☐ Spouse ☐ Child ☐ Patient ☐ Other

Name: _____ Date of Birth: _____

Relationship to Patient: ☐ Spouse ☐ Child ☐ Patient ☐ Other

Name: _____ Date of Birth: _____

Relationship to Patient: ☐ Spouse ☐ Child ☐ Patient ☐ Other

May we leave messages regarding appointments and lab results on your answering machine? ☐ Yes ☐ No

Phone number to leave message: _____

Signed: _____ Date: _____
(Patient or parent/legal guardian if patient is minor)