

**Sharam Daneshgar, MD**

GASTROENTEROLOGY

DIPLOMATE OF THE AMERICAN BOARD OF  
INTERNAL MEDICINE AND GASTROENTEROLOGY

**HIPAA Privacy Rule Individual Authorization Agreement**

**Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))**

I, ..... understand that as part of my health care, Sharam Daneshgar, MD's originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my health care;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals

I have been provided with and understand the Sharam Daneshgar, MD's *Notice of Information Practices* provides a more complete description of the information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review Sharam Daneshgar, MD's *Notice of Information Practices* prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

PHI Authorized:

Purpose Authorized:

Parties to whom my PHI is authorized to be released:

I understand that:

- I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations by other covered entities;
- I may revoke this consent in writing at any time, except to the extent that Sharam Daneshgar, MD has already taken action in reliance thereon.

Accepted     Denied

**Patient Authorization for Office Procedures**

Our office is "HIPAA Compliant" and our staff has been trained in the "HIPAA Privacy Act". We will do everything we can to protect your Patient Health Information (PHI). However, our office is designed before the HIPAA Law so please be respectful of other patients' privacy.

We are required by the insurance companies to prove that you were here in our office on the date of service that we are billing for. Our office procedure to prove that you were here is that we have a daily sign in sheet which you sign and put the time of your appointment.

1. How would you like us to address you, by your first name or last name?  
.....
2. It is our office procedure that we call you regarding medical issues. If you are not home, whom may we leave the message with?  
.....
3. If no one is at home to take our call, may we leave a message on your answering machine?  
Yes                  No

I agree to all of the above office procedures of Sharam Daneshgar, M.D. and I give my authorization to all of the above-mentioned procedures.

**Acknowledgement of Receipt of Information Practices Notice (§164.520(a))**

I understand that as part of my health care, Sharam Daneshgar, MD originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand Sharam Daneshgar, MD's, *Notice of Privacy Practices* which provides a complete description of the uses and disclosures of my health information.

I understand that:

- I have the right to review Sharam Daneshgar, MD's *Notice of Privacy Practices* prior to signing this acknowledgement;
- That Sharam Daneshgar, MD, reserves the right to change his *Notice of Privacy Practices* and prior to implementation of this will mail a copy of any revised notice to the address I've provided if requested.

Signature of Individual or Legal Representative Witness:

Printed Name of Individual or Legal Representative Witness:

Date: .....