Dr. Sue Mitra, MD
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Melbourne, FL 32935
Phone: (321) 622-6222

HIPAA RELEASE

(Name)	(Relationship)	(Phone)

(Name)	(Relationship)	(Phone)

Signed _____ Date _____/_____/_____

I authorize Medical Associates of Brevard to leave a detailed message on my voicemail.

Signed _____ Date _____/_____/_____

Notice of Privacy Practices

I acknowledge that I have received a copy of the Provider Notice of Privacy Practices for Medical Associates of Brevard. The Provider Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Provider Notice of Privacy Practices also describes my right and the responsibilities of duties of Medical Associates of Brevard with respect to my protected health information.

Print Name of Patient or Personal Representative

Signature of Patient or Personal Representative Date

Signature of Witness Date