**Dr. Sue Mitra, MD**
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# HIPAA RELEASE

I authorize Medical Associates of Brevard to discuss my health care information with:

Name:_____ (Relationship):_____ Phone Number (_____) _____-_____

Name:_____ (Relationship):_____ Phone Number (_____) _____-_____

Signed:_____ Date:_____/_____/_____

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

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:_____/_____/_____