Sheila C. Lally, DO, PS
Communication and HIPAA Form

Communication Authorization

Patient Name: _____Date of Birth__/__/__
Last First MI

I,_____, (☐Patient ☐Parent/Guardian) give permission to Dr. Sheila Lally and staff to discuss my medical and/or financial information with the following people, as needed, as it pertains directly to my care:

Name:_____ Relation:_____ Phone:_____

Name:_____ Relation:_____ Phone:_____

Name:_____ Relation:_____ Phone:_____

Consent for Use and Disclosure of Private Health Information - HIPAA

Purpose of Consent: By signing this form, you consent to our using and disclosing your protected health information in order to treat you, collect payment, and care for your health.

Notice of Privacy Practices: A copy of our Notice of Privacy Practices can be found in our office and on our website, www.drlally.com. It provides a detailed description of how we may use your protected health information. Before signing this consent, we encourage you to carefully read our Notice of Privacy Practices.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, and you will be asked to sign this consent again.

Changing Your Permissions: If your household situation changes, it is your responsibility to file a new Communication Authorization with us. If you fail to notify us, we are not responsible for unwanted communication. The permissions you give on this form will be considered current until you file an updated form with us.

Right to Revoke: You have the right to revoke this consent at any time. To do so, give written notice of your revocation to Dr. Sheila Lally. Revocation of consent will not apply retroactively. Revoking this consent may mean that Dr. Lally may decline to treat you, or to continue treating you.

Signed: _____Date: _____
Patient/Parent/Guardian's Signature