Majed Jandali, MD FACS
Mustafa Badrudduja, MD FACS

JANDALI SURGICAL ASSOCIATES

9555 76th St Suite 4880
Pleasant Prairie, WI. 53158
(262) 748-1001 tel
(262) 748-1020 fax

HIPAA NOTICE AND CURES ACT

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

The HIPAA Privacy Rule (Health Insurance Portability and Accountability Act) provides individuals with the right to request confidential communications or that a communication of PROTECTED HEALTH INFORMATION be made by other means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply)

Home telephone number ______________________
□ Please leave a call back number only
□ I give permission to leave a message with detailed information

Cell phone number ______________________
□ Please leave a call back number only
□ I give permission to leave a message with detailed information

Work telephone number ______________________
□ Please leave a call back number only
□ I give permission to leave a message with detailed information

Exceptions to the above: ____

Emergency Contact: Relation to patient: Phone:
Do you authorize your PROTECTED HEALTH INFORMATION to be disclosed to your emergency contact?
□ YES □ NO

□ I authorize my PROTECTED HEALTH INFORMATION to be disclosed verbally or in writing to the following:

Name	Relationship	Phone #
Name	Relationship	Phone #
Name	Relationship	Phone #

OR

□ My PROTECTED HEALTH INFORMATION is not to be released to any person other than myself

CURES ACT

The information blocking (aka "open notes") rule of the federal 21st Century Cures Act dictates certain information created in an electronic health record (EHR) must be immediately available to patients through a secure online portal. Test results may be available for you (the patient) to see, even before the provider has seen them. It is important to understand that not all abnormal test results are clinically significant, nor urgent. It may take several days for the provider to review the results. Patients will be contacted sooner if urgent or emergent action is required. Certain test results may require a follow-up appointment to fully discuss and form a treatment plan.

The signature below affirms that the information provided above is to the best of my knowledge
This form remains in effect for one year from the date of signature.

Signature ____________________________ Date: ____________________

Printed Name ____________________________ Relationship to Patient ____________________
(if someone other than patient is signing)