South Shore Speech, Language and Swallowing Disorders, PLLC

400 Montauk Highway, Suite 152, Babylon, NY 11702
Phone: 631-669-7098 Fax: 631-669-3736

NOTICE OF HIPPA / PRIVACY POLICIES

I understand that South Shore Speech, Language and Swallowing Disorders, PLLC may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluation of the quality of services provided and any administrative operation related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that South Shore Speech, Language and Swallowing Disorders, PLLC will consider requests for restriction on a case-by-case basis, but does not have to agree to requests or restrictions.

Authorization for Disclosure of Protected Health Information

I authorize South Shore Speech, Language and Swallowing Disorders, PLLC to release my records and test results, and any information pertaining to my care to (Who we can contact regarding your information):

(Please Check)				
	Physicians	☐Yes	☐No	Specific:_____
	Family Members	☐Yes	☐No	Specific:_____
	Insurance Company	☐Yes	☐No	Specific:_____
	Other	☐Yes	☐No	Specific:_____

I authorized the use of the following means of communication by South Shore Speech, Language and Swallowing Disorders, PLLC for the transfer of my records and authorization information (How we can contact the above persons):

(Please Check)				
	Telephone	☐Yes	☐No	Home #_____
	Cell Phone	☐Yes	☐No	Cell #_____
	Fax	☐Yes	☐No	Fax #_____
	Mail	☐Yes	☐No	Address_____
	Email	☐Yes	☐No	Email_____

I authorize South Shore Speech, Language and Swallowing Disorders, PLLC to contact me by (How we can contact you):

(Please Check)				
	Telephone	☐Yes	☐No	Home #_____
	Cell Phone	☐Yes	☐No	Cell #_____
	Fax	☐Yes	☐No	Fax #_____
	Mail	☐Yes	☐No	Address_____
	Email	☐Yes	☐No	Email_____

I give permission for a message to be left for me on my answering machine (Not a detailed message):

(Please Check) ☐Yes ☐No

Note: I understand that I retain the right to revoke this consent by notifying South Shore Speech, Language and Swallowing Disorders, PLLC in writing at any time.

_____
PATIENT AND OR RESPONSIBLE PARTY

_____
SIGNATURE OF PATIENT AND OR RESPONSIBLE PARTY

_____
DATE