



**HIPPA NOTICE OF PRIVACY PRACTICES**

Dr. Jamie Gottlieb

We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our main phone number. Please return this signed form to the front desk to be placed in your patient file.

Print Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

**STANDARD AUTHORIZATION OF USE AND DISCLOSURE  
OF PROTECTED HEALTH INFORMATION**

**Information regarding my medical condition may be disclosed to:**

| Name  | Relationship | Phone Number |
|-------|--------------|--------------|
| _____ |              |              |
| _____ |              |              |

**Expiration Date of Authorization**

This authorization is effective unless revoked or terminated by the patient or the patient’s personal representative.

**Right to Terminate or Revoke Authorization**

You may revoke or terminate this authorization by submitting a written revocation to Dr. Jamie Gottlieb.

**Permission to Leave Message**

Authorization for information regarding patient to be left by message to person or machine at designated phone number.

Print Name \_\_\_\_\_ Date \_\_\_\_\_

Dr. Jamie Gottlieb is part owner of the Unity Surgery Center in Mishawaka, IN. The physician believes that any and all of their subsidiaries are appropriate settings for this medical care and services for which you are being referred. Nevertheless, the selection of a specific health care provider always rests with the patient, and you may choose to be referred to an alternate setting if you so desire.

Print Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_