David A. Gentile, DO, ABAARM, ABIHM
Board Certified Diplomate Physician
Main Office
797 Route 25A
Rocky Point, NY 11778
(t) 631.821.4200
(f) 631.821.6226
www.oasismedicine.com

Patient HIPAA Form

For Medical and Medical Marijuana Patients

Updated January 2021

Patient Name: _____ Date: _____

I, or my authorized representative, request health information regarding my care and treatment be released as set forth on this form. I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG TREATMENT, MENTAL HEALTH TREATMENT and CONFIDENTIAL HIV/AIDS-RELATED INFORMATION only if I sign the appropriate line down below. In the event the health information described below includes any of these types of information and I sign the appropriate line down below, I specifically authorize release of such information to the person(s) listed below.
2. With some expectations, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of HIV/Aids-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human rights at 1-888-392-3644. This agency is responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be confidential upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

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Please only fill out Section I or Section II

SECTION 1

I, _____, give the practice of David A. Gentile, DO, CAC, PC. permission to leave medical information at the following: (see below)

1. Home Answering Machine: _____
2. Cell Voicemail: _____
3. Office Voicemail: _____

Please check all information that can be left on the above answering machine(s):

- ☐ Test Results
- ☐ Lab results
- ☐ Confirming appointments
- ☐ Medication changes
- ☐ Billing/insurance inquires
- ☐ Any information pertaining to all aspects of my medical care (includes all of the above).

Family member(s) or designated representative(s): Please print and list full name and relationship.

1. Name: _____ Phone: _____
   May receive the following information:
   _____
2. Name: _____ Phone: _____
   May receive the following information:
   _____
3. Law Office of: _____ Phone: _____
   May receive the following information:
   _____

Signature _____ Date: _____

Relationship to patient (if minor, or signed by personal representative(s): _____

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SECTION II

I, _____, do not want my information pertaining to all aspects of medical care left on my answering machine or with anyone other than myself.

I understand that I may revoke/amend this authorization at any time, if it is in writing.

Signature _____ Date: _____