AUTHORIZATION ACKNOWLEDGEMENT

WNY RHEUMATOLOGY CENTER
1825 Maple Road, Suite 2A, Williamsville, NY 14221
Sunita Chadha, M.D.

I understand that, under the Health Insurance Portability & Accountability Act of 1998 (HIPAA), I have certain rights to privacy regarding m protected health information. I understand that this information can only be used for the following purposes:

- Conduct, plan, and direct treatment and follow-up treatments among multiple healthcare providers who may be involved in that direct or indirect treatment
- Obtain payment for third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I am aware of my rights to obtain and read the WNY Rheumatology Center's Notice of Privacy containing a more complete description of the uses and disclosure of my health information. I understand that this organization has the right to change its Notice of Privacy from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the updated Notice of Privacy.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations.

I have read this form and all of my questions about this form have been answered. By signing below, I acknowledge that I have read and accept all of the above statements.

Patient Name:_____

Signature: _____

Date _____

(You have a right to obtain a copy of this acknowledgement after you sign it.)

****I concur that below is the written authorization to release any information regarding my medical data and/or billing reports to the following person(s):**

Name:_____

Relationship to Patient:_____

Contact telephone number: _____

Emergency Contact:Same as above: _____

Name: _____

Telephone number: _____ Relationship to patient: _____