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As a result of the Health Insurance Portability and Accountability Act (HIPAA), enforced by the US Department of Health and Human Services office of Civil Rights, the Office of the Inspector General, OSHA, and HCFA, I am not permitted to release patient information except as stated in the Notice of Privacy Practices or in accordance with your wishes as stated below.

This waiver authorizes Steven M. Rosman, PhD, MS, LAc, LMHC to send/give my clinical information as noted:

Leave a voice mail recording on my home/cell phone Yes _____ No _____
Leave a voice mail recording on my business phone Yes _____ No _____

Permit an individual other than myself to pick up supplements and other nutraceuticals or tests results
_____ Yes _____ No _____

Speak to a family member of my choosing: _____ Yes
_____ No _____

Information may be mailed to my home Yes _____ No _____

On this date _____ I received and reviewed this Notice of Privacy Practices which describes how my medical information may be used and disclosed and explains how I can gain access to this information.

I had an opportunity to raise questions regarding this policy and all of my questions have been answered.

This will remain effective until such time as I notify Steven M. Rosman, PhD, MS, LAc, LMHC in writing by certified mail.

Patient Signature

Date

Social Security Number

Date of Birth