JUAN C. YORDAN, MD PA
FAMILY PRACTICE
929 North US Highway 441/27 Suite 102 Lady Lake, Florida 32159
PHONE 352-633-0473 ● FAX 352-775-9562

HIPAA Authorization Form

Juan C Yordan Family Medicine has taken measures to protect all of our patient's private medical information. We will not release any information to anyone unless you have provided the requested information below.

HIPAA (Health Insurance Privacy & Accountability Act) does allow us to release information to outside entities on your behalf. For Example, another medical office we have referred you to, your insurance company, your pharmacy, or hospital.

Please see receptionist with any questions prior to signing this Authorization Form.

I, _____ am authorizing the person/people listed below to obtain medical information about myself. I understand that Juan C Yordan Family Medicine is not responsible for the information provided if it is given to a person that I have listed below.

1. Name: _____ Date of Birth: _____
2. Name: _____ Date of Birth: _____
3. Name: _____ Date of Birth: _____
4. Name: _____ Date of Birth: _____

I acknowledge and agree that Juan C Yordan, MD P.A. may:

__: Leave a message regarding upcoming appointments.

__: Leave a message regarding lab results, imaging studies, and medication refill on my home answering machine/cell voicemail.
__: Leave a message regarding billing questions on home answering machine/cell voicemail.

I have read and understood the information in this consent. I may receive a copy of this consent if I so choose. I, the patient or the authorized legal guardian of the patient sign this document verifying consent to the above terms.

Patient Name: _____ **Date**: _____

Patient/ Legal Guardian Signature: _____