Communication / Medical Release From

The Privacy Rule generally requires healthcare providers to take reasonable steps to minimize the protected health information (PHI) requests, usage and disclosure for only what is required to meet the intended need. These provisions do not apply to uses or disclosures made pursuant to an authorization request by the individual.

_____ Do Not Provide health information regarding diagnosis, treatment, billing, and appointments with anyone but me.

_____ I give permission to receive my health information regarding diagnosis, treatment, billing, and appointments.

AUTHORIZED REPRESENTATIVES

I give permission for the following people listed to receive the following PHI elements as specified below.

Name_____ Relationship_____

___ Appointments ___ Billing ___ Discuss my treatment and diagnosis

Name_____ Relationship_____

___ Appointments ___ Billing ___ Discuss my treatment and diagnosis

Name_____ Relationship_____

___ Appointments ___ Billing ___ Discuss my treatment and diagnosis

I have read the Privacy Notice and understand my rights contained in the Notice. By way of my signature, I provide this practice with authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

Patient's Name (print)_____

Patient's Signature_____ Date:_____

_____ Date:_____

Authorized Facility Signature