Release of Information Policy – Please Read

HIPAA AUTHORIZATION

STATEMENT OF INTENT

It is my understanding that Congress passed a law entitled the Health Insurance Portability and Accountability Act ("HIPAA") that limits disclosure of my protected medical information. This authorization is being signed because it is crucial that my medical providers readily give my protected medical information to the persons designated in this authorization in order to allow me the advantage of being able to discuss and obtain advice from my family and/or friends.

Therefore, pursuant to 45 CFR 164.501(a)(1)(iv) a covered entity (being a healthcare provider as defined by HIPAA) is permitted to disclose protected health information pursuant to and in compliance with this valid authorization under 45 CFR Sec. 164.508.

AUTHORIZATION

I, _____, an individual, hereby authorize all covered entities as defined in HIPAA, including but not limited to a doctor, (including but not limited to a physician, podiatrist, chiropractor, or osteopath,) psychiatrist, psychologist, dentist, therapist, nurse, hospitals, clinics, pharmacy, laboratory, ambulance service, assisted living facility, residential care facility, bed and board facility, nursing home, medical insurance company or any other healthcare provider or affiliate, to disclose the following information:

> All healthcare information, reports and/or records concerning my medical history, condition, diagnosis, testing, prognosis, treatment, billing information and identity of healthcare providers, whether past, present, or future and any other information which is in any way related to my healthcare. Additionally, this disclosure shall include the ability to ask questions and discuss this protected medical information with the person or entity who has possession of the protected medical information even if I am fully competent to ask questions and discuss this matter at the time. It is my intention to give a full authorization to ANY protected medical information to the persons named in this authorization.

I hereby authorize David A. Ramos, M.D., P.A., dba R Family Medical Group to use and/or disclose my health information which specifically identifies me, or which can reasonably be used to identify me to carry out my treatment, payment, and other healthcare operations.

RFMG
R FAMILY MEDICAL GROUP

INDIVIDUAL #1	INDIVIDUAL #2
NAME: _____	**NAME:** _____
ADDRESS: _____	**ADDRESS:** _____
PHONE: _____	**PHONE:** _____
RELATIONSHIP TO PATIENT: _____	**RELATIONSHIP TO PATIENT:** _____
INDIVIDUAL #3	**INDIVIDUAL #4**
NAME: _____	**NAME:** _____
ADDRESS: _____	**ADDRESS:** _____
PHONE: _____	**PHONE:** _____
RELATIONSHIP TO PATIENT: _____	**RELATIONSHIP TO PATIENT:** _____

Additional pages can be provided upon request

I acknowledge that I have been provided the "Notice of Privacy Practices" for *ll*. I acknowledge that I have completed this form and certify that I am the patient or duly authorized to finish the information requested.

_____ _____

Patient or Authorized Representative Signature Date