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8901 Activity Road, San Diego, CA 92126
Tel. (844) 627-4763 Fax: (760) 635-7801
499 N. El Camino Real Ste C-200 Encinitas, CA 92024
Tel. (760) 635-7800 Fax: (760) 635-7801

Patient Name: _____ **DOB:** _____ **Account #:** _____

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

In accordance with the Federal Government Privacy Rules implemented through the Healthcare Portability Act of 1996 (HIPAA), I, _____, hereby authorize *OASIS MD* to release any and all medical records concerning my care to any physician, hospital or other health care professional providing care to me at any time.

I also authorize *OASIS MD* to discuss my condition, treatment or diagnosis to the following family members, individuals and/or caregivers:

_____ _____
(Name) **Relationship**

_____ _____
(Name) **Relationship**

Home Phone: _____ **May we leave a detailed message:** **YES/NO**
Cell Phone: _____ **May we leave a detailed message:** **YES/NO**
E-Mail: _____ **May we send you a detailed message:** **YES/NO**

_____ _____
PATIENT SIGNATURE **DATE**

ACKNOWLEDGEMENT OF PRIVACY PRACTICES NOTICE RECEIPT

I, _____, understand that under the Healthcare Portability Act of 1996 (*HIPAA*) I have certain rights to privacy regarding my Protected Health Information (*PHI*). I understand that this information can and will be used to:

- **Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in my treatment directly and indirectly**
- **Obtain payment from Third-Party Payers**
- **Conduct normal healthcare operations such as quality assessments and physician certifications**

I have received, read and understand your Notice Of Privacy Practices containing a more complete description of the uses and disclosures of my *PHI*. I understand that this organization has the right to change its Notice of Privacy Practices 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 Notice of Private Practices.

I understand that I may request in writing how my *PHI* is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

_____ _____
PATIENT SIGNATURE **DATE**

OFFICE USE ONLY

I attempted to obtain the patient's signature to confirm receipt of the Notice of Privacy Practices but was unable to do so as documented below:

Date:	Initials:	Reason: