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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:
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