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### Authorization for Release of Medical Information

**Patient** \_\_\_\_\_ **Birth Date** \_\_\_\_\_

I acknowledge that I have received a copy of the Notice of Privacy Practices (available at our office or on our website, www.ripondocs.com). I understand that I may amend or revoke these authorizations at any time by submitting a signed and dated notice. This authorization will remain valid unless I revise and sign a new form.

I authorize the release of medical information to and from other physicians or medical facilities in order to effectively manage my medical care.

#### Please check YES or NO:

◆ **Voicemail Messages:** I give permission for the office to leave a voicemail message with appointment information, test results, referrals, recommendations and other messages, on the phone number(s) that I have provided.  YES  NO

◆ **Mail:** I give permission for the office to mail correspondence including appointment and lab reminders, test results, and other information regarding my health care to the address that I have provided.  YES  NO

◆ **Authorized Contacts:** I give permission for the office staff to speak with the following individuals regarding my healthcare:  NONE, only myself

\_\_\_\_\_ Phone # \_\_\_\_\_  
\_\_\_\_\_ Phone # \_\_\_\_\_  
\_\_\_\_\_ Phone # \_\_\_\_\_  
\_\_\_\_\_ Phone # \_\_\_\_\_

◆ **Discretionary Disclosure:** I choose to leave decisions regarding the disclosure of my health care information to the discretion of Dr. Dutter, Dr. Hufford, Dr. Daley and their staff, believing that they maintain the best interest of my health and medical well-being.  YES  NO

#### Acknowledgement of Financial Responsibility

◆ I authorize the release of medical and other information necessary to process medical claims. I authorize payment of insurance claims be made to the physician.

◆ I assume responsibility for payment of medical services that are not a covered benefit of my insurance. Covered benefits may be verified by contacting the Customer Service Department of the insurance.

◆ I assume responsibility for charges incurred if correct, current, and complete insurance information is not presented at the time of service.

**Signature of Patient/Guardian/Representative** \_\_\_\_\_ **Date** \_\_\_\_\_

*If this authorization is NOT signed by the patient, complete the following information:*

Printed Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ Representative's Phone # \_\_\_\_\_