HIPAA/ Release of Information

- Protected Health Information (PHI) may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The patient has the right to request restrictions on the use of the information, but the practices does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time, and all full disclosures will then cease.
- The practice may require execution of this consent to receive treatment.

May we leave a message on your answering machine at home or on your cell phone? ☐ YES ☐ NO
May we discuss your medical condition with any other member of your family? ☐ YES ☐ NO

I hereby authorize the following individual(s) noted below to have full access to my medical information and to receive results on my behalf from Rancho Paseo Medical Group and, moreover, authorize this disclosure after being provided any answers to questions regarding my privacy rights.

names of individuals authorized to access my medical records and/or bring me in for care & appointments:

name of individual	relationship to patient	date of birth	phone number

Assignment of Benefits

I hereby authorize payment of benefits be made directly to Rancho Paseo Medical Group for services provided to me by Rancho Paseo Medical Group. I understand that I am financially responsible to Rancho Paseo Medical Group for charges not covered by this assignment. I authorize refund of overpaid insurance benefits whenever my coverages are subject to coordination of benefits. In the event of default, I agree to pay all costs for collection, including reasonable attorney's fees. This authorization will remain in effect until revoked in writing by the undersigned.

☐ **I have read and fully understand all of the information above and hereby agree to comply as outlined.**

Patient's name
(Please print.)

Responsible Party's name
(if different from Patient's name)
(Please print.)

Patient's and/or Responsible Party's signature

______/______/______
date

If signed by someone other than the patient, please select your legal relationship to the patient:

☐ Parent ☐ Guardian ☐ Spouse ☐ Representative ☐ Financially Responsible Party