HIPAA Release Form

We at REAL Medicine, LLC are committed to safeguarding the privacy and confidentiality of your medical records including the personal information that you share with us: We comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Please complete all sections of this HIPAA release form. If any sections are left blank, this form will be invalid and it will not be possible for your health information to be shared as requested.

Section I

I,_____, give my permission for _____ to share the information listed in Section II of this document with the person(s) or organization(s) I have specified in Section IV of this document.

Section II – Health Information

I would like to give the above healthcare organization permission to:

Check as appropriate

☐ Disclose my complete health record including, but not limited to, diagnoses, lab test results, treatment, and billing records for all conditions.

Or

☐ Disclose my complete health record except for the following information

- ☐ Mental health records
- ☐ Communicable diseases including, but not limited to, HIV and AIDS
- ☐ Alcohol/drug abuse treatment records
- ☐ Genetic information
- ☐ Other (Specify)

_____

_____

_____

_____

Form of Disclosure:

☐ Electronic copy or access via a web-based portal

☐ Hard copy

Section III – Reason for Disclosure

Please detail the reasons why information is being shared. If you are initiating the request for sharing information and do not wish to list the reasons for sharing, write ‘at my request’.

_____

_____

_____

_____

_____

Section IV – Who Can Receive My Health Information

I give authorization for the health information detailed in section II of this document to be shared with the following individual(s) or organization(s)

Name: JENNIFER FERGUSON, PA-C

Organization: REAL Medicine, LLC

Fax Number: (830) 323 - 0163

I understand that the person(s)/organization(s) listed above may not be covered by state/ federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them.

Section V – Duration of Authorization

This authorization to share my health information is valid:

Tick as appropriate

☐ a) From _____ to _____

Or

☐ b) All past, present, and future periods

Or

☐ c) The date of the signature in section VI until the following event:

_____

I understand that I am permitted to revoke this authorization to share my health data at any time and can do so by submitting a request in writing to:

Name: JENNIFER FERGUSON, PA-C

Organization: REAL Medicine, LLC

Fax Number: (830) 323 - 0163

I understand that:

- In the event that my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health data.

- I understand that I do not need to give any further permission for the information detailed in Section II to be shared with the person(s) or organization(s) listed in section IV.
- I understand that the failure to sign/submit this authorization or the cancellation of this authorization will not prevent me from receiving any treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.

We will continue to rely on the information on this form when communicating with family members or others involved in your care unless you request changes. Please promptly notify out office if you wish to alter the designations above.

I have been made aware of the privacy policies of REAL Medicine, LLC and have received or been given the option to receive a copy of the HIPPA Notice of Privacy Practices.

Section VI – Signature

Signature: _____ Date: _____

Print your name: _____

If this form is being completed by a person with legal authority to act an individual's behalf, such as a parent or legal guardian of a minor or health care agent, please complete the following information:

Name of person completing this form: _____

Signature of person completing this form: _____

Describe below how this person has legal authority to sign this form:

_____

_____

_____

_____

Section VII - Authorization Form for Communication:

Patient Name:
How would you like to be addressed:
Date of Birth:

Contact Preferences:

____Cell _____

May we use this number for Telehealth visits? Y / N
May we leave a voicemail for you on this line? _____Y / N
May I Text appointment and Invoice information to this line? Y / N
May we discuss details via text? If so, what is allowed?_____

____Email_____

May I send reports, follow up questions, and communicate through this email? Y / N

Please list any family member or other whom may be involved in coordinating your care or payment for care. Also please indicate what information you would like to be shared with each individual.

Name:
Relationship to Patient:
Phone Number:
Type of Information to be shared:

Emergency Contact:_____Phone:_____

Relationship to the Patient:_____

May we speak to this person regarding your care? Y / N

Your Name:_____ Date:_____

Signature Authorizing Above:_____