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Release of information according to HIPAA, notice of Privacy Practices

In accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, notice of Privacy Practices, your doctor and the staff at Mission Ranch Primary Care must have WRITTEN permission to speak with any other person, such as your spouse, caregiver, family member, friend, etc. regarding your care.

You may designate the person(s) of your choice in the spaces provided below. In doing this, you are giving our office permission to speak to these individuals regarding your treatment, test results, billing, appointments, prescriptions, etc. **Anyone not indicated on this form will not be given access to your information.**

This form does not apply to other treating physicians, only to family and friends.

This form is effective for any services delivered. Only the most current signed version of this form will be considered valid. Any previously signed forms will be deemed void. To void the current agreement, written notice must be received.

I, _____, give Mission Ranch Primary Care providers and staff authorization to communicate with the following person(s) in regards to my care:

Name	Relationship	Phone

I do not wish to designate anyone. _____ (Initials)

Signature

Date