Raleigh Adult Medicine, P.A. a division of Raleigh Medical Group

HIPAA AUTHORIZATION FORM

Chart#:_____ Date:_____

I give my permission for the providers of Raleigh Adult Medicine, P.A. (a division of Raleigh Medical Group) to release ANY information about my medical condition, prescriptions, and financial account to:

Name:_____ Name:_____

Name:_____ Name:_____

Below, I give my permission for the providers of Raleigh Adult Medicine, P.A. (a division of Raleigh Medical Group) to release prescriptions, samples, forms, and medical records to:

Name:_____ Name:_____

Name:_____ Name:_____

Is it ok to mail protected information to your home? YES_____ NO_____

The above mentioned person(s) **will be required to provide photo ID** when picking up requested items.

Patient Name:_____ Date of Birth_____

Patient Signature:_____

By signing on the line below, I acknowledge that I was provided access to the Notice of Privacy Practices of Raleigh Adult Medicine, P.A.(a division of Raleigh Medical Group).

Print Name:_____ Date of Birth_____

Patient Signature:_____

Sensitive information such as HIV results, STD results, abnormal results, and diagnoses will not be left as messages. Information regarding sexually transmitted diseases will only be released to the patient.

The information discussed between you and your healthcare provider is strictly confidential. Please indicate below any individual(s) allowed to accompany you into the exam room.

Name:_____ Name:_____

For Personal Representation of the Patient (if applicable)

Print Name of Personal Representative:_____

Representative's Relationship (i.e. parent/guardian/other, etc.):_____

Signature of Personal Representative:_____

_____ I refuse to acknowledge I was provided access to the Notice of Privacy Practices of Raleigh Adult Medicine, P.A. (a division of Raleigh Medical Group).

Signature of Practice Employee_____ Date_____