



Dr. Matthew A. Schmid and Dr. Brian Ransone
7116 Six Forks Rd. Raleigh, NC 27615

**Authorization for disclosure of health information and direct
Our Privacy Pledge**

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, we understand that we have, and always will, respect the privacy of your health information.

Disclosures of protected health information

There are several reasons for having to use or disclose your PHI (personal health information)

- We may have to disclose your information to another healthcare provider or hospital should we refer you to them for a diagnosis, assessment, or treatment of your health condition.
- We may have to disclose PHI and/or billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your PHI within our practice for quality control or operational purposes.

Your right to limit uses or disclosure.

- You have the right to request that we do not disclose your health information to specific individuals, companies or organizations. If you would like to place any restrictions on the use or disclosure of your PHI, we will respectfully request that you submit these restrictions in writing.

We have a more complete notice that provides a detailed description of how your information may be used or disclosed. You have the right to review that notice before you sign this consent form. (164.520)

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their PHI. The individual is also provided the right to request confidential communications, such as reminders of appointment times, follow up of health care, insurance coverage's/benefits issues or any other information that only the patient will personally be able to answer.

I wish to be contacted in the following manner (check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Home Telephone | <input type="checkbox"/> Office Telephone |
| <input type="checkbox"/> Leave message with detailed information | <input type="checkbox"/> Leave message with detailed information |
| <input type="checkbox"/> Leave message with call back number only | <input type="checkbox"/> Leave message with call back number only |
| <input type="checkbox"/> Written communication | <input type="checkbox"/> Cell phone |
| <input type="checkbox"/> OK to mail to my home address | <input type="checkbox"/> Leave message with detailed information |
| <input type="checkbox"/> OK to mail to my office address | <input type="checkbox"/> Leave message with call back number only |

Patient Signature _____
Date _____

Print Name _____ Birth _____