Rheumatology and Dermatology Associates, PC
Cathy M. Chapman, MD
George R. Woodbury Jr., MD

AUTHORIZATION TO DISCUSS MY CARE AND/OR ACCOUNT STATUS WITH ANOTHER PERSON

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) prohibits this office from discussing a patient's care and/or account information with any other person than the patient or the guardian of a minor and in some cases the legal guardian of an adult under such care. For this reason, your permission is needed if you want your medical and/or account information to be disclosed to another party. Once such permission is given, this permission will remain in effect until revoked in writing by the patient or by the guardian of a minor patient.

I give Rheumatology and Dermatology Associates, PC permission to discuss my medical care and/or account information with the following person(s):

Name	Relationship	Medical info	Account info
____________________________	_______________	Y / N	Y / N
____________________________	_______________	Y / N	Y / N
____________________________	_______________	Y / N	Y / N

Please check one space below:

I give____ do not give____ Rheumatology & Dermatology Associates permission to leave information about appointments and requests to return calls on my voicemail or answering machine or with another person at my place of residence.

____________________________________ ________________________________
Patient Name (print) Printed Guardian Name (if applicable)

________________________________ _____________________________
Patient or Guardian Signature Relationship to Patient

____
Date

OFFICE FEES DISCLOSURE

A fee of $25.00 will be charged by Rheumatology and Dermatology Associates for any physician appointment that is missed without notice and for physician appointments that are cancelled with less than 24 business hours notice.

Rheumatology and Dermatology Associates requires a $20.00 pre-payment for any drug prior authorizations.

I acknowledge that I have been informed of the Office Fees of Rheumatology and Dermatology Associates, PC. disclosed above.

________________________________ _____________________________
Patient Name (print) Printed Guardian Name (if applicable)

________________________________ _____________________________
Patient or Guardian Signature Relationship to Patient

____
Date