Amjad Rass Inc.

HIPAA

HIPAA is an acronym for the Health Insurance Portability & Accountability Act of 1996 (a federal law). Of significant concern to healthcare organizations is the Administrative Simplification section of the Act, which requires healthcare organizations to comply with specific rules regarding:

- Unique identifiers for health plans, providers, individuals, employers.
- Healthcare Transaction & Code Sets for transmitting data electronically.
- Privacy Regulations over disclosure and use of health information.
- Security Regulations over protection of electronic health information.

All of these rules have been developed by the Department of Health & Human Services.

It is the office policy of Amjad Rass, M.D. and staff to not release confidential and/or unauthorized information by home telephone answering machine, work telephone, voice mail, cell phone, and/or pagers. Whenever returning telephone calls and the answering machine picks up, we do not leave a message if the name or telephone number is not on the recorded message to identify the residence. Information will also not be left with an unauthorized person who may answer the telephone.

If you would like to have information released to someone other than yourself, please complete the following:

I authorize Amjad Rass, M.D. and/or his staff to leave medical information pertaining to my care by the following methods and will assume responsibility to Amjad Rass, M.D. whenever this information changes.

MAY WE CALL OR LEAVE MESSAGE

	YES	NO
Home phone _____	_____	_____
Answering Machine _____	_____	_____
Work Telephone _____	_____	_____
Voice Mail _____	_____	_____
Cell Phone _____	_____	_____
Fax medical records for referral to Another entity _____	_____	_____

----- please turn over to other side -----

Please list names of authorized people that we can leave medical information with:

Spouse: _____

Parent: _____

Other Names (please list relationship such as boyfriend, fiance, girlfriend, sister, brother, etc.):

_____Relationship_____

_____Relationship_____

_____Relationship_____

Patient/Guardian Signature: _____

Date: _____

You have the right to amend this release at any time however, if you wish to make revisions to this agreement, it must be done in writing.

Name and signature of person financially responsible for the bills:

_____

(Please print and sign)