Scott Rusco, D.O., INC.
Release Of Health Information
Consent Form

This consent is being requested by this office because of the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). Your signature is needed in order to provide your health care.

I understand that Dr. Rusco may need to use and disclose information about my health or medical problems for the purposes of arranging, conducting, or referring my treatment; for obtaining payment for services; and for operating the practice.

I understand that my consent is not needed if the law requires Dr. Rusco to report some aspect of my protected health information to a government agency (for example, suspected abuse, communicable disease, and potential for serious bodily harm to myself or others).

I understand that I have the right to review Dr. Rusco's privacy notice, to request restrictions on the use of my information, and to revoke my consent at a later date.

I understand that if I withhold consent for the use of my information for purposes of treatment, payment, or operations, Dr. Rusco may refuse to undertake my care.

I, ______________________________ will allow my health information, test results, and billing
Patient Name
to be discussed with the following people (such as spouse, children, or friend):

Person	**Relationship**
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

May we leave test results on your answering machine or voice mail?

	NORMAL	**ABNORMAL**
Home Phone: ____________________________	Yes / No	Yes / No
Work Phone: ____________________________	Yes / No	Yes / No
Other: ________________________________	Yes / No	Yes / No

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Signature

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Printed Name Date