Robert David Tufft MD

HIPAA Release Form

Patient Name_____

Privacy federal regulations require us to have signed releases by our patients prior to speaking with other professionals, family members and friends regarding your medical problems and treatment.

Family and friends to whom you authorize "Release of Information" must be listed individually.

( ) I authorize Dr. Tufft to release information to other professionals concerning my care.

( ) I authorize Dr. Tufft to release additional information concerning my care, aside from diagnosis, for the purpose of insurance pre-authorization for testing or medications.

( ) I authorize Dr. Tufft to give information regarding my condition to:

Name	Relation	Phone#

Signature_____ Date_____