Reedsburg
AREA MEDICAL CENTER

MRN: _____

Patient Full Name:_____ Patient Date of Birth:____/____/____

Communication Authorization/Medical Decision Making

1. Reedsburg Area Medical Center, Inc. Physicians and Specialty Group representatives may contact me at home/cell/work numbers (including message machine and voice mail) or my home address regarding appointments, diagnosis, test results, treatment, problems with your account, resolve a dispute, collect a debt, or as otherwise necessary to serve your account, or enforce our policies, applicable law, or any other agreement we may have with you.
2. This does not consent the below listed **individuals** to request and obtain medical records.
3. I authorize Reedsburg Area Medical Center, Inc. Physicians and Specialty Group staff members to share *my* medical/billing information about my care/account to the following and/or allow the individual to make medical decisions on my behalf:

Name(s)/Relationship to Patient	Phone Number(s)	Communication or MDM?	
_____/_____	_____	☐	☐
_____/_____	_____	☐	☐
_____/_____	_____	☐	☐
_____/_____	_____	☐	☐
_____/_____	_____	☐	☐

Communication authorization shall expire under any circumstances listed below:

1. Upon written request by patient or legally responsible person.
2. Upon written request of records release for transfer of care.
3. In the case of a minor reaching age of maturity.

_____ _____
Patient/Guarantor Signature Date

Patient/Authorized Representative Name (Printed/Relationship): _____/_____

Please return this to RAMC via mail or FAX to 608-524-2104, Attention HIM

NEW: 2/21 REVISED: 10/21 10/2023 2/2024
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