MRN: ______________________________

Communication Authorization

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. 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:

Name(s)	Relationship	Phone Number(s)
______________________________	____________________	____________________
______________________________	____________________	____________________
______________________________	____________________	____________________
______________________________	____________________	____________________
______________________________	____________________	____________________

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): ______________________________________

Patient Date of Birth:_____/_____/_____

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

NEW: 2/21 REVISED: 10/21
Distribution: Department Focused Manual – Business Services
/Communication Authorization