

## Communication Consent Agreement

JON J. ATIGA M.D., INC.  
25405 HANCOCK AVE. STE. 108  
MURRIETA, CA 92562

This form allows our physicians and office staff permission to speak with your family members or other individuals noted below.

I, \_\_\_\_\_ understand that under Federal Law (HIPAA) this medical office may not release any medical information to any individual without my expressed written permission for my child \_\_\_\_\_  
(Patient Name)

Law enforcement and court order are two exceptions to this requirement. I, therefore, give permission to Jon J. Atiga M.D. Inc., and staff to release medical information on my behalf to the following individuals. I understand that Dr. Atiga and staff can refuse to discuss private health information if believed that it is in the best interest of the patient. **I understand that I will be required to fill out a complete medical release form for copies of records.**

1. Name: \_\_\_\_\_ Relationship \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Date of Birth \_\_\_\_\_
2. Name: \_\_\_\_\_ Relationship \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Date of Birth \_\_\_\_\_
3. Name: \_\_\_\_\_ Relationship \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Date of Birth \_\_\_\_\_

The authorization to release protected health information specifically to individuals named herein shall remain valid until revoked by a subsequent signed writing or unless a court order executed after this authorization prohibits the release of information.

Parent or legal Guardian Signature \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date of Birth \_\_\_\_\_

Signature Date: \_\_\_\_\_

**PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES  
AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM**

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

**JON J. ATIGA M.D., INC.**

25405 Hancock Ave. Ste. 108

Murrieta, Ca 92562

Phone: 951-304-7854 Fax: 951-304-7855

Date: \_\_\_\_\_

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

**MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.**

\_\_\_\_\_  
Please **print** name of Patient

\_\_\_\_\_  
Please **sign** for Patient / Guardian of Patient

\_\_\_\_\_  
Legal Representative / Guardian

\_\_\_\_\_  
Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: \_\_\_\_\_

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA?

First Name Only  Proper Surname  Other \_\_\_\_\_

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:

(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

- |  |  |
|--|--|
| <input type="checkbox"/> Cell Phone Confirmation | <input type="checkbox"/> Text Message to my Cell Phone |
| <input type="checkbox"/> Home Phone Confirmation | <input type="checkbox"/> Email Confirmation            |
| <input type="checkbox"/> Work Phone Confirmation | <input type="checkbox"/> <b>Any of the Above</b>       |

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

- |  |  |
|--|--|
| <input type="checkbox"/> Cell Phone Confirmation | <input type="checkbox"/> Text Message to my Cell Phone |
| <input type="checkbox"/> Home Phone Confirmation | <input type="checkbox"/> Email Confirmation            |
| <input type="checkbox"/> Work Phone Confirmation | <input type="checkbox"/> <b>Any of the Above</b>       |

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

- |  |   |
|--|---|
| <input type="checkbox"/> Phone Message | <input type="checkbox"/> <b>Any of the Above</b>            |
| <input type="checkbox"/> Text Message  | <input type="checkbox"/> <b>None of the above</b> (opt out) |
| <input type="checkbox"/> Email         |   |

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

**Office Use Only**

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

- |  |       |
|--|-------|
| It was emergency treatment               | _____ |
| I could not communicate with the patient | _____ |
| The patient refused to sign              | _____ |
| The patient was unable to sign because   | _____ |
| Other (please describe)                  | _____ |

\_\_\_\_\_  
Signature of Privacy Officer