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
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