Daniel M Burchfield, MD • Bertrand P Kaper, MD • Judah D Pifer, MD • Brad D Williams, MD

Brian K Barnes, PA-C • Marie I Thomas, PA-C • Sherry L. Booz, ANP-C

Medical Information (HIPAA) Release Form

This form MUST be completed in its entirety

Name:_____

DOB:_____ SSN:_____

Mailing Address:_____ City:_____ St:____ Zip:_____

Physical Address: _____ City:_____ St:____ Zip:_____

Should we need to contact you and you are not available; is there someone we could speak with regarding any medical information or financial/insurance information?

Name:_____ Phone:_____ Relationship:_____

How may we contact you? Is it ok to leave a message?

Primary Phone # _____Main/Home/Cell yes / no

Secondary Phone # _____ Main/Home/Cell yes / no

Email: _____

Emergency Contact: _____ Relationship:_____ Phone:_____

Secondary Contact: _____ Relationship:_____ Phone:_____

Do you have Advance Directives (Living Will)? Yes No

****IF YES – PLEASE BRING WITH YOU TO YOUR APPOINTMEMT***

I acknowledge and am aware of the Notice of Privacy Practices: Yes No

Release of Information I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

- ○ Spouse: _____
- ○ Children: _____
- ○ Other: _____

○ Information is **not** to be released to anyone.

This Release of information will remain in effect until terminated by me in writing.

Signature:_____ Date:_____

Patient or legally authorized individual

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ONE TIME AUTHORIZATION

Name:_____ DOB:_____

Consent for Treatment: I authorize performance of necessary medical and/or surgical treatments. These medical services are to be performed by a licensed medical professional and/or appropriate staff of their choice in the medical facility of their choice. (i.e. office, hospital, outpatient facility, etc.)

If patient is a minor, who is authorizing treatment:

Name:_____ DOB:_____ SSN:_____

Relationship:_____ Driver's License:_____ Phone: _____

I hereby authorize the above listed providers to furnish information to **Insurance Carriers/Workers Compensation** concerning my illness and treatments and information needed to determine benefits or benefits for related services. I hereby authorize payment of insurance benefits directly to the above listed billing provider. I acknowledge full responsibility for all charges incurred, regardless of possible insurance coverage. I further agree to pay all collection fees, attorney fees and other collection costs that may be incurred to enforce collection of any amount outstanding.

I request that payment of authorized **Medicare** Benefits be made directly to the above listed billing provider for any services furnished to me by that provider. I authorize the holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

I hereby authorize the release of medical records to and from all hospitals, medical service companies, insurance companies and other physicians assisting in the care of the patient. Authorization is also given for a copy of office notes to be mailed to the patient if requested.

Signature:_____ Date:_____