

***Acknowledgement of Receipt of Notice of Privacy Practices***

Printed Name of Patient: \_\_\_\_\_

Patient's Representative & Relationship \_\_\_\_\_

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

Reason for Patient Refusal to Sign: \_\_\_\_\_

***Patient Authorization***

RELEASE OF MEDICAL RECORDS: In order to ensure proper follow up and continuity of care, I agree that a copy of my medical records may be released to my physician, a designated referral physician, and/or the provider, if any, who referred me here.

INSURED AUTHORIZATION: I request that all payment of authorized benefits be made to the above named doctor on my behalf for any services provided to me. I authorize any holder of medical and other information about me to release to Medicare and its agent, any insurance company, and any other third party payer, State medical assistance agency, or any other governmental or private payer responsible for paying such benefits, any information needed to determine these benefits or benefits for related services. I agree to pay for all charges not covered by a third party payer.

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