Patient Authorization Form

Please use blue or black ink to fill out this form and sign below.

Patient Name:_____ Date of Birth: _____ Date: _____

Because of the changes made by Congress, we are required to get your explicit permission regarding how your medical information is handled. You may request a copy of the Notice of Privacy Practices from our staff. Please read each authorization carefully and indicate your approval by initialing on the line provided.

- I authorize the release of all medical records maintained by The Surgical Clinic, PLLC, which relates to services I have received from, or the results of tests ordered by The Surgical Clinic, PLLC. These records may be released as needed for my care for the processing of insurance claims, to satisfy the requirements of a managed care organization of which I am a member, and/or to my attorney regarding pending or anticipated litigation under a worker's compensation, motor vehicle accident, and/or third party liability claim.

- I am giving permission for The Surgical Clinic and its sub-specialties (listed below) to obtain my prior films, scans, labs, and any records including demographic, pharmacy and medication history that may identify me and that relates to my past, present, and/or future physical or mental health or condition and related health care services . I understand that it is my responsibility to obtain previous studies, if asked to do so. If it is necessary for an employee of The Surgical Clinic to obtain my prior films, labs, and/or other records, I am giving my permission to call and/or fax on my behalf in order to get needed medical records and films.

- I authorize direct payment of benefits from my insurance plan to The Surgical Clinic, PLLC. I understand that I am responsible for payment of professional fees charged by the Surgical Clinic, PLLC, which are not covered or not properly reimbursed under the terms of my insurance plan.

  The Surgical Clinic, PLLC, will file your insurance or collect self-pay accounts. You, the patient, will be responsible for any personal balance. Any account turned to an outside collection agency will accrue additional fees on the unpaid balance including any attorney/court costs in collecting that balance.

- I will provide The Surgical Clinic, PLLC, with the phone numbers I authorize to be used to contact me. I authorize the use of any messaging person or system, voice mail and/or answering machine to convey information regarding my care. Contact via e-mail is authorized, if I provided my e-mail address to The Surgical Clinic.

- I authorize the use of fax or e-mail to send my information to myself or other parties that have a right to receive my information. I understand that every effort is made to protect my privacy, however, no absolute privacy guarantee is given when faxes or e-mails are used.

- I understand that it is my right to request limited access to my records and to withdraw permission for the release of my records. I understand that this request must be in writing and that limiting or withdrawing my permission may result in the Surgical Clinic, PLLC, discontinuing its relationship with me. In that case, I will need to seek care from another source.

Signature: _____ Date: _____

I have been offered a copy of The Surgical Clinic's Notice of Privacy Practices for my own records. Initials: _____

My signature above also gives my permission and consent for any and all medical information maintained in or generated by The Surgical Clinic on my behalf to be released and/or discussed with the following person(s):

_____ _____ _____ _____

Patient's family member's name *Relationship* *Patient's family member's name* *Relationship*