Patient Authorizations

Release of information Authorization:

I, the undersigned, authorize the release of any information required in the course of my treatment to my insurance carrier or other health provider I am consulting.

_____ initial

Assignment of benefits authorization:

I, the undersigned, assign to the provider(s) or supplier all insurance payments for the medical services rendered. I also acknowledge responsibility for payment of all medical fees in the event they are not paid by my insurance company.

_____initial

HIPPA / Privacy policy

I, the undersigned, have been provided with the Tryon Urgent and Family Care HIPPA / Privacy care policy and understand that this document will be in effect, by my signature, for 12 months. I understand that any information that I provide to an outside source regarding my visit in this office may no longer be protected by federal or state law/ HIPPA policy for Tryon Urgent and Family Care. This information may be used by entities I authorized to receive it for medical treatment/consultation/billing/claim payment or other purposes as I direct with regard to my visit at Tryon Urgent and Family Care.

_____initial

Date _____/_____/_____

_____ Signature of patient or Personal Representative (proof of legal representation is required for patients <18 years of age)

_____ Printed Name