Please sign and date each item below

ACKNOWLEDGEMENT AND AUTHORIZATION:

- **I have read and understand the HIPAA/Privacy Policy for Community Healthcare Consultants dba Community Medical Center**

Signed: _____ **Date:** _____

- **I hereby assign my insurance benefits to be paid directly to the healthcare provider**

Signed: _____ **Date:** _____

- **I authorize Community Healthcare Consultants dba Community Medical Center to release medical information required to process my claim**

Signed: _____ **Date:** _____

- **I authorize Community Healthcare Consultants dba Community Medical Center to obtain/have access to my medication history**

Signed: _____ **Date:** _____

- **I authorize my provider's office to contact me by mobile phone**

Signed: _____ **Date:** _____