LAUREL CREEK
FAMILY MEDICINE

**RELEASE OF INFORMATION:** I hereby authorize Laurel Creek Family Medicine to furnish any information from my medical records to:

- any insurance company or third party payer, or to any agent or representative of said insurance company or third party payer, for the purpose of obtaining payment for the services provided to me
- any physician or facility to which I may be referred, to any extended care facility that I may be considered for placement and state agencies for the purpose of providing additional information regarding my care

I understand that the information contained and released may contain medical information related to treatment of alcohol abuse, psychiatric care, substance abuse information and/or HIV/AIDS, as applicable.

**HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT (HIPAA):** In accordance with the HIPAA of 1996, Laurel Creek Family Medicine has made available for my review their Notice of Information Practices.

**ASSIGNMENT OF BENEFTIS:** I authorize direct payment of benefits to Laurel Creek Family Medicine. I understand that I am personally responsible to Laurel Creek Family Medicine for charges not covered by insurance, including charges for routine healthcare services. I hereby agree to pay Laurel Creek Family Medicine for all charges incurred that are not paid by such insurance company(ies) and agree that any contractual liability of an insurance company to pay shall not relieve me of my independent obligation to pay Laurel Creek Family Medicine until such insurance company(ies) actually make(s) payment of all fees charged to my account.

**TRANSFER OF CREDIT:** I hereby authorize the transfer of monies paid to Laurel Creek Family Medicine on behalf of myself and otherwise refundable to me to other facility accounts for which I am responsible.

**VOICEMAIL MESSAGES:** By checking the box below, I hereby authorize Laurel Creek Family Medicine to leave detailed messages regarding appointments, test results or billing information at the contact number(s) listed in my medical record.

☐ YES, leave a message. ☐ DO NOT leave messages pertaining to _____.

**E-PRESCRIBING:** Laurel Creek Family Medicine may send your prescriptions electronically to your local or mail-order pharmacy. I hereby authorize Laurel Creek Family Medicine to perform an External Medication History check. (*This provides information about current and older prescriptions written by our office or other providers.)*

_____

*Print Patient Name* *Patient Signature* *Date*

_____

*Signature of Other Authorized Person* *Relationship to Patient* *Date*