Primary PartnerCare®

Primary PartnerCare Physicians, PLLC

Patient Authorization Form

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the results of tests, procedures, and financial information. We are only allowed to give this information with the appropriate patient consent. If you wish to have your medical information (including any diagnostic test results) and/or financial information released to any family members, you must complete and sign this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

At my request, I authorize Primary PartnerCare permission to **VERBALLY** discuss the following information with the below individuals:

Individual's Name	Relation to Patient	Financial Information	Medical Information
1.	1.	☐ Yes ☐ No	☐ Yes ☐ No
2.	2.	☐ Yes ☐ No	☐ Yes ☐ No
3.	3.	☐ Yes ☐ No	☐ Yes ☐ No

At my request, I authorize Primary PartnerCare permission to leave a **detailed message** with the following:

Detailed Messages can be left on the following of MY phone numbers:	Financial Information	Medical Information
Home Number	☐ Yes ☐ No	☐ Yes ☐ No
Cell Number	☐ Yes ☐ No	☐ Yes ☐ No
Work Number	☐ Yes ☐ No	☐ Yes ☐ No

Detailed Messages can be left on the following of my family member's phone numbers:	Financial Information	Medical Information
1. Name: _____ Relationship: _____ Phone Number: _____	☐ Yes ☐ No	☐ Yes ☐ No
2. Name: _____ Relationship: _____ Phone Number: _____	☐ Yes ☐ No	☐ Yes ☐ No
3. Name: _____ Relationship: _____ Phone Number: _____	☐ Yes ☐ No	☐ Yes ☐ No

Patient Name (Please Print): _____

Patient Signature: _____

Date: _____

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Assignment of Benefits to Primary PartnerCare Physicians, PLLC

I do hereby assign all medical and/or surgical benefits to which I am entitled, including all government and private insurance plans or other payers, for service rendered by

PRIMARY PARTNERCARE PHYSICIANS, PLLC, and the medical professionals caring for me during my treatment in this office to be paid directly to PRIMARY PARTNERCARE PHYSICIANS, PLLC, or other associated providers as appropriate. I understand that I am responsible for all charges not paid by insurance. This assignment will remain in effect until revoked in writing by me.

Acknowledgement of Receipt of Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Practices and Consent

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. It also provides information about your rights as a patient of our practice and whom you may contact at our office to ask questions about our privacy practices.

By signing this form, I hereby acknowledge that I have had the opportunity to read the Notice of Privacy Practices of PRIMARY PARTNERCARE PHYSICIANS, PLLC and understand that in compliance with that notice, PRIMARY PARTNERCARE PHYSICIANS, PLLC is allowed to use or disclose my individually identifiable health information for purposes of treatment, payment, and health care operations. I further understand that the Notice of Privacy Practices provides a more complete explanation of the use or disclosure of my individually identifiable health information.

I have read a copy of the PRIMARY PARTNERCARE PHYSICIANS, PLLC 's HIPAA Notice of Privacy Practices and understand the information it contains.

Authorization to Release Billing Information

I hereby authorize the treating provider to release any information required in the course of my examination or treatment to my insurance company, providers, individuals and entities authorized by me or their contracted entities. [If the patient is a minor, the parent or legal guardian must sign].

Please note that the use of all daily authorized and released records are not under PRIMARY PARTNERCARE PHYSICIANS, PLLC control.

AUTHORIZATION FOR PATIENT PICTURE: I hereby authorize PRIMARY PARTNERCARE PHYSICIANS, PLLC to take a picture for my electronic medical records if I do not produce a current Photo ID.

Signature of Patient/Patient's Authorized Representative	Date
Patient's Name (Please Print)	Date of Birth