Valley View Family Practice Associates

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UNIFORM ASSIGNMENT AND RELEASE OF INFORMATION STATEMENTS

Name:_____ DOB:_____

I hereby authorize any Valley View Family Practice Physician to review any medical records prepared by any other physician where services are rendered relating to my care and treatment. I hereby further authorize release of information in relation to medical treatment by any physician at Valley View Family Practice and the appropriate facility, to governmental agencies, insurance carriers, or others who are financially liable for my hospitalization and medical care or to the facility where services are rendered, laboratories or others, for the purpose of billing and collecting fees for medical services provided on my behalf and to permit representatives thereof to examine and make copies of all records relating to such care and treatment.

_____ _____
Date Signature of Patient or Authorized Representative

I hereby assign to the treating physicians of Valley View Family Practice sufficient monies and/or benefits to which I may be entitled from governmental agencies, insurance carriers, or to others who are financially liable for my hospitalization and medical care to cover the costs of the care and treatment rendered to myself or my dependent in said facility or hospital.

_____ _____
Date Signature of Patient or Authorized Representative

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have been provided a copy of, or been offered the opportunity to receive the Valley View Family Practice Notice of Privacy Practices.

_____ _____
Date Signature of Patient or Authorized Representative

FOR PATIENTS ENTITLE TO MEDICARE BENEFITS LIFETIME AUTHORIZATION

I certify that the information given to me in applying for payment under Title XVIII for the Social Security Act is correct. I authorize any Valley View Family Practice holder of medical information or other information about me to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this on my behalf to the physician or organization furnishing the services provided to me. I authorize any holder of medical information about me to release to the MEDIGAP insurer any information needed to determine these benefits or the benefits payable for related services. I request that payment under the medical insurance program be made either to me or to any physician for services provided to me.

_____ _____
Date Medicare Beneficiary Signature