HIPAA RELEASE OF INFORMATION / AUTHORIZATION FORM

I authorize the release of any medical information necessary to my Insurance carrier to process this claim. I permit a copy of this authorization to be used in place of the original. I hereby authorize the physician(s) to apply for benefits on my behalf for services rendered. I certify that the information I have reported with regard to my insurance coverage is correct and accurate. I authorize the physician(s) to treat me and / or my child.

PATIENT GENERAL CONSENT FOR TREATMENT

I authorize the release of my medical records only to myself:

For patients receiving medical treatment services from ___________________________________.
I am voluntarily seeking medical care and treatment for myself and voluntarily do consent to ambulatory care services which may include routine diagnostic and therapeutic procedures. Medical treatment to be provided by duly licensed independent practitioners (Physicians, Nurse Practitioners or PA's)

PATIENT / INSURED AUTHORIZATION

I authorize the release of my medical information necessary to process claims on my behalf.

Patient Signature:___________________________________ **Date:** ________________

*****Please note: As a patient you will be the only person that receives your test results. The company you work for, employers, insurance providers will not have any access to your test results or medical records**