

## **Authorization & Consent of Medical Information**

HIPAA requires a list of all individuals to whom you are granting access to your medical information. This form will allow authorized individuals to receive information regarding appointments, test results, account status and any other information regarding treatment or services provided by our facility.

**I allow the following individuals to have access to my medical records:**

1. \_\_\_\_\_ 3. \_\_\_\_\_  
2. \_\_\_\_\_ 4. \_\_\_\_\_

- Yes, Please leave me a detailed message via Text, Email or Vociemail regarding all results .  
 No, please do leave me a detailed messge via Text, Email or Vociemail with all results.

Printed Name : \_\_\_\_\_ D.O.B: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of patient : \_\_\_\_\_

The privacy rule requires Health Care Providers to take reasonable means to limit the use of disclosure of and request for PHI. We will do all in our means to accomplish the intended purpose. These provisions do not apply to notes or disclosures made in pursuant to an authorized request by an individual. Health Care entities must keep record of PHI disclosures provided below. Uses and disclosures may be permitted without prior consent in case of an emergency. I authorize the release of medical records or financial information necessary to process any claims. I authorize my insurance company if applicable to make payments to AFHP for medical treatment. I also agree that the filling out of any medical claim with insurance company is not guarantee of payment. In the event that my claim is denied, I will be responsible for the balance. There is a filing deadline for every insurance company. Please be aware that if you do not bring a current insurance card within 60 days of your visit you will be responsible for the balance due.