



CONSENT TO ARRANGE FOR PAYMENT AND RELEASE INFORMATION

Patient Name:

MR/CPI:

We are required by law to ask you to sign this form each year. This form is important to your privacy rights.

ARRANGING PAYMENT

- Assignment of Benefits and Responsibility for Payment: *This allows us to bill your health plan directly. It also means that you agree to pay for services not covered by your health plan.*
- I authorize my caregiver to bill my health plan directly on my behalf. I agree that it is my responsibility to pay for any healthcare services not covered by my health plan, including but not limited to co-payments, deductibles or co-insurance.

RELEASING INFORMATION

- For Care, Payment and Operations: *This allows us to coordinate your care with other caregivers and to bill your health plan. This also allows your health plan to process your claims and provide other services to you.*
- I authorize my caregiver to release information from my health records to other caregivers for treatment, payment or other health care operations for my benefit.
- I authorize my caregiver to release information from my health records for purposes of processing and paying claims, coordinating benefits, coordinating care, quality of care review studies, and other functions that support treatment, payment and healthcare operations, including those functions that my caregiver is required by my health plan to perform.
- I authorize my health plan to release my health information to appropriate accreditation and quality review/measurement personnel, to disease, pharmacy, or case management providers and to other third parties for purposes related to treatment, payment, or healthcare operations on my behalf.
- For Health Research: *This allows us to share limited information about you with external health researchers. Health research advances new and better ways to prevent, diagnose and treat illness. This research could benefit you and your family directly and the community as a whole. All medical research involving the use and disclosure of individual health records is legally required to get prior review and approval from an Institutional Review Board. The Board is charged with the protection of research subjects, confidentiality and conducting research responsibly.*
- I authorize my caregiver to release limited information about me to external health researchers in accordance with federal law.
- If you do not wish to have this information shared with external health researchers, you can check this box.

SIGNATURE AND ACKNOWLEDGEMENT

I understand that I may revoke (cancel) this consent, in writing, at any time. Revoking consent does not apply to information that has already been disclosed. I also acknowledge that a copy of my caregiver's notice of privacy practices has been made available to me.

Signature

Date

Signature of Parent or Representative (Relationship)

Date

For Internal Use Only -