GENERAL AUTHORIZATION FORM TO TREAT AND CONSENT TO RELEASE INFORMATION

Patient Name: _____ **Date of Birth:** _____ **Gender:** ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Street Address: _____ City: _____

State: _____ **Zip:** _____ **Email:** _____

I HEREBY AUTHORIZE DIRECT PAYMENT OF SURGICAL/MEDICAL BENEFITS TO DR. PATEL AND OR HIS ASSOCIATES FOR SERVICES PROVIDED BY HIM IN PERSON OR UNDER HIS SUPERVISION. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE NOT COVERED BY INSURANCE. ALSO, I HEREBY AUTHORIZE DR PATEL AND OR HIS ASSOCIATES TO RELEASE ANY MEDICAL OR INCIDENTAL INFORMATION THAT MAY BE NECESSARY FOR EITHER MEDICAL CARE OR IN PROCESSING APPLICATION FOR FINANCIAL BENEFIT. I UNDERSTAND THAT IF PAYMENT IS NOT MADE IN A TIMELY MANNER, I MAY INCUR LATE AND OR COLLECTION FEES ON ALL OVERDUE BALANCES ON MY ACCOUNT.

1. I hereby authorize the release of my protected health information, including account status, test results, scheduled appointments, and information regarding my treatment, to the person(s) I have listed below. Any person who is not listed will not be able to obtain protected health information. It is not necessary to list other treating physicians or insurance companies.

Name: _____ Phone: _____ Rel: _____
Name: _____ Phone: _____ Rel: _____
Name: _____ Phone: _____ Rel: _____

2. Phone Number(s), Fax(s) - ALTERNATE WAYS, WE MAY CONTACT YOU:

_____ OK to leave voice message

3. Emergency Contact (s)- AT Least one is required:

Name: _____ Phone: _____ Rel: _____
Name:_____ Phone: _____ Rel: _____

Signature of the release REVOKES any previously signed release on file. We reserve the right, in accordance with our Notice of Privacy Practices, to release information if we feel there is a serious threat to the health or safety of a patient. This Authorization is to be in effect until instructed by patient in writing to change any of the above.

I (or my legal guardian/parent) authorize GetWell Internal Medicine Clinic to provide medical care that is reasonable for today's standards.

Patient or Surrogate Name: _____ **Signature:** _____ **Date:** _____