

Authorization and Release

I certify that the information provided above is true and correct to the best of my knowledge and belief. I authorize the physician to release any information including diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the physician's office, insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I understand I am responsible for all copays, deductibles, co-insurance and balances. I personally agree to pay for any and all services provided to me at the rates in effect during the time services are rendered. I understand and agree that my bill for services rendered is due and payable at the time of services and that I am ultimately responsible for any unpaid balances. A wide variety of means for communication exists and continues to broaden and develop. By signing this Authorization, I agree that this office, and any third party used for treatment, billing, collection, and other services, may use any means of communication with me. Thus, I understand and agree that any phone numbers and email addresses provided by myself to this office and to any of our service providers may leave messages for me manually and by using automated systems such as by artificial or prerecorded voice. Specifically, if I provide a cellular phone number, I consent and agree to accept collection calls and other communications to my cellular phone from this office and from any of our service providers. For any landline and cellular phone calls that this office or any service providers may contact me by sending text messages and emails to any phone number or email address I provide to this office or service providers, and I consent to receive such text messages and emails which may identify the name of this office or service provider sending the communication, and which may disclose the nature of this communication. In the future, should I acquire a new or different cellular, landline, or email address, I agree that this consent would stay effective.

I have been offered or received a copy of the SUNNY MEADOW MEDICAL CLINIC, PC Notice of Privacy.

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with NE State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. SUNNY MEADOW MEDICAL CLINIC, PC uses SureScripts, Inc, a prescription system that allows prescription and related information to be exchanged between my providers and the pharmacy. The information sent between these systems may include details of any and all prescription drugs I am currently taking and/or have taken in the past. The information will be utilized to SUNNY MEADOW MEDICAL CLINIC,PC.
2. This authorization may include disclosure of prescriptions information related to alcohol and drug abuse, mental health treatment, and/or HIV related information by SureScript,Inc to SUNNY MEADOW MEDICAL CLINIC,PC.
3. I have the right to revoke this authorization at any time by writing to SUNNY MEADOW MEDICAL CLINIC, PC. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be re-disclosed by the recipient, and this re-disclosure may no longer be protected by state or federal law.
6. THIS AUTHORIZATION DOES NOT AUTHORIZE SUNNY MEADOW MEDICAL CLINIC, PC TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THOSE PERMITTED UNDER APPLICABLE LAW.

•Please list person/s to whom health information may be disclosed to:

Name	Relationship	Phone Number

•Emergency Contact, someone not living with you:

Name	Relationship	Phone Number

•Email: _____

Signature: _____ **Date:** _____