TOLEDO BEND FAMILY MEDICINE

(TBFM)

ALL AUTHORIZATIONS MUST BE SIGNED BY THE PATIENT OR BY THE NEAREST RELATIVE IN CASE OF A MINOR, OR WHEN PATIENT IS PHYSICALLY OR MENTALLY INCOMPETENT.

1. Medical or Surgical Permit.
   I, the undersigned or authorized party, hereby consent to medical or surgical procedures, x-ray exam or treatment, drugs (oral and/or injectable), and supplies which treating physicians or physician assistants deem necessary. I understand that there are inherent risks with any of these procedures.

2. Authorization for Release of Physician Responsibility.
   If I should leave before completing my medical or surgical procedures, examinations or treatment, I hereby release said physician or physician assistant and the clinic of any responsibility for medical condition.

3. Consent for Release of Medical Information.
   I hereby authorize SFMC/TBFM to furnish any representative of the insurance company(s) under whose policy of insurance I am entitled to benefits for the payment of expenses of my medical treatment by the clinic with any information desired by said company(s) for the completion of any claims resulting from medical treatment.

4. I hereby authorize the SFMC/TBFM to furnish to any facility to which I am transferred any information as may be deemed necessary by the Clinic. I hereby release the Clinic from all legal liability or responsibility that may arise from the release of such records.

5. I hereby authorize payment directly to the physician of any insurance benefits otherwise payable to me for this period of treatment. I understand that I am financially responsible to the clinic for charges not covered by this authorization

6. I have been informed that the clinic routinely provides medical care through mid-level practitioners. Physician Assistants or Advanced Certified Nurse Practitioners are supervised by the clinic's physicians and at all times can communicate with a physician when necessary.

7. I have been advised of the required privacy regarding my medical records as mandated by the HIPAA regulations. A complete copy of the policy has been made available to me. Because of the privacy regulations we must have your approval to discuss your medical condition with members of your family. Please indicate two family members with whom we may discuss your medical information:

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Name Address Phone Number Relationship

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Name Address Phone Number Relationship

<u>YOUR SIGNATURE INDICATES APPROVAL OF ALL THE ABOVE UNLESS OTHERWISE MARKED AND INITIALED</u>

Date ______________________ Patient Signature ____________________________________

Witness______________________ or: ____

Relationship to Patient:

If the patient is a minor or unable to sign, complete the following:

Reason patient is unable to sign ____

___________________________________ ___________________________________

Witness Witness

This authorization remains in effect unless revoked in writing.