Alden Medical Group PLLC

12845 Broadway

Alden, NY 14004

Patient Authorization and assignment of Benefits agreement and HIPAA form

I _____ authorize Alden Medical Group to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations.

With my consent, Alden Medical Group may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out my healthcare treatment, such as appointment reminders, insurance items and any call pertaining to my clinical care, including test results.

Alden Medical Group may release any medical records or office visits, test results, treatment to another physician or healthcare provider for the purpose of discussing my case or reviewing my medical records via fax or mail.

These records in their entirety, regardless of dates of coverage may also be released to the Dept of Health & Human Services, Medicare or my insurance company to which I subscribe. Employees of the insurance companies and the Physicians Health Organizations (PHO) which contract with my insurer for the purpose of payment, insurance reimbursement, submitting claims for services rendered to me, or performing quality assurance reviews as required above.

I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts assignments/ physician. I understand it is mandatory to notify the health provider of any other party who may be responsible for paying for my treatment.

All professional services rendered are charged to the patient if the complete insurance information is not given at the time of service. If Alden Medical Group Dr.s are not listed as your primary care physician for the date of service, the patient is responsible for the referral or payment of all charges from that date of service.

Patient signature: _____

Date _____ DOB _____

Authorized persons/ agents to receive protected health information:

Name :_____ relationship to pt :_____

Name :_____ relationship to pt:_____

Exceptions (mental health, drug/ alcohol use:_____