AUTHORIZATION TO TREAT/ HIPAA

THE UNDERSIGNED HERBY AUTHORIZES SOUTH FLORIDA ENDOCRINE CENTER AND ANY PHYSICIAN WHO PROVIDES SERVICES TO RELEASE INFORMATION (INCLUDING TREATMENT FOR DRUG AND ALCOHOL ABUSE TO INSURANCE COMPANIES, INDIVIDUALS INVOLVED IN YOUR CARE, OR PAYMENT FOR YOUR CARE, RESEARCH, TREATMENT, REQUIRED BY LAW (FEDERAL, STATE OR LOCAL) TO PREVENT SERIOUS THREAT TO YOU OR ANOTHER PERSONS HEALTH OR SAFETY, THE SOCIAL SECURITY ADMINISTRATION OR ITS INTERMEDIARIES OR MEDICAL ASSISTANCE PROGRAMS (INCLUDING THEIR AGENTS, REPRESENTATIVES OR ASSIGNEES) OR ANYTHIRD PARTY PAYOR THROUGH WHICH PAYMENT OR BENEFITS IN CONNECTION WITH HOSPITAL AND/OR PHYSICIAN SERVICES ARE, OR MAY BE, AVAILABLE. WE DISCLOSE MEDICAL INFORMATION TO CONTACT YOU AS A REMINDER THAT YOU HAVE AN APPOINTMENT FOR TREATMENT AND ALL CHARGES FOR SERVICES ARE DUE AT THE TIME OF SERVICES UNLESS OTHER FINANCIAL ARRANGEMENTS HAVE BEEN MADE IN ADVANCE. THE PATIENT IS RESPONSIBLE FOR ALL FEES REGARDLESS OF COVERAGE.

PATIENT
SIGNATURE _____ DATE _____

PATIENT AGENT OR
REPRESENTATIVE _____ DATE _____

HIPAA PRIVACY ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I HAVE BEEN PRESENTED WITH THE NOTICE OF PRIVACY PRACTICES OF SOUTH FLORIDA ENDOCRINE CENTER (LAMINATED COPY ATTACHED, I MAY REQUEST A COPY FOR MY RECORDS AT ANY TIME)

PATIENT
SIGNATURE _____ DATE _____

PATIENT AGENT OR
REPRESENTATIVE _____ DATE _____