INSURANCE AUTHORIZATION

I hereby authorize **Orchard Medical Center, S.C. (OMC, S.C.)** to release any medical information necessary to process insurance claims on behalf of myself or my dependants. I hereby assign **OMC, S.C**. the benefits to which I or my dependants are entitled to under my health insurance/s. I understand that I am financially responsible for all charges. **(YOUR INSURANCE COMPANY/CARRIER DOES NOT ASSUME FINANCIAL RESPONSIBILITY FOR ANY UNPAID CLAIMS.)**

THE ABOVE AUTHORIZATION APPLIES TO ALL COVERAGE TYPES: INDEMNITY, PPO, POS, HMO, AND WORK COMP.

______________ ____________________________________

(DATE) **(SIGNATURE)**

MEDICARE LONG TERM AUTHORIZATION

I hereby authorize release of any **PHI** to or from **CMS (Centers for Medicare and Medicaid Services)** when necessary, in order to process my claims. I also authorize payments from my insurance programs to be made directly to **OMC, S.C.** for any services furnished by this provider. I further permit copies of this authorization to be used in place of the original.

______________ ____________________________________

(DATE) **(SIGNATURE)**

SUMMARY OF OUR NOTICE OF PRIVACY PRACTICES

This summary of our Notice of Privacy Practices applies to patients and, as applicable, their parent(s), legal guardians or other authorized personal representatives.

Who Will Follow The Notice Of Privacy Practices:

This Notice describes the privacy practices of **OMC, S.C.** and all of its members.

Our Pledge Regarding Patient Information:

We understand that patient information about you, your child(ren) and spouse is personal. We are committed to protecting the confidentiality of patient information. Our complete Notice of Privacy Practices describes how we may use and disclose your patient information without your written authorization to provide treatment, obtain payment for services, conduct our health care operations, or for other purposes that are permitted or required by law. When required by law, we will obtain your authorization before using or disclosing any of your patient information. It also describes your rights to access and control your patient information. “Patient information” is information that may identify the patient and that relates to the patient’s past, present or future physical or mental health or condition and related health care services or payment for such services.

Your Rights Regarding Patient Information About You:

You have the following rights regarding patient information we maintain about you:
Right to receive a copy of our complete Notice of Privacy Practices
Right to inspect and copy patient information in your medical or billing records
Right to request an amendment of patient information in your medical or billing records
Right to an accounting of certain disclosures made by us
Right to communicate with us via alternative means or have communications sent to alternative locations
Right to request restrictions on how we use or disclose your patient information
Right to revoke an authorization given to us
Although you have these rights, we may deny your requests if they do not meet certain requirements.
If you have any questions about this Notice, your privacy rights described above or believe your privacy rights have been violated, please contact **OMC, S.C.** or you may file a complaint with the Director of the Office for Civil Rights of the U.S. Department of Health and Human Services.

NOTICE OF PRIVACY PRACTICES RECEIPT FORM

I understand by signing this form, I give my consent for **OMC, S.C.** to use or disclose any and all information contained in my electronic or paper record for the purpose of carrying out treatment, payment, and/or all other health care operations. I also acknowledge receipt of my physician’s Notice of Privacy Practices.

______________ ____________________________________

(DATE) **(SIGNATURE)**

AUTHORIZATION TO DISCUSS MY CASE WITH FAMILY OR THIRD PARTY PERSONS

I authorize the physicians and staff of **OMC, S.C.** to discuss my case with the following family members or third party persons, when necessary, to expedite my care, and/or the processing of claims. I understand that I may revoke this consent by sending written notice of my desire to do so to the Privacy Official at **OMC, S.C**. I understand that I will not be able to do so when the physician has already relied on it to use or disclose my health information. I understand any person NOT listed will NOT receive any **PHI** information about me.

________________________ ______________________

(NAME) **(RELATIONSHIP)**

________________________ ______________________

(NAME) **(RELATIONSHIP)**

________________________ ______________________

(NAME) **(RELATIONSHIP)**