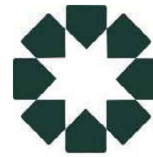
Office Use Only:
EPM _______



Complete Family Medicine
A service of Hannibal Regional

Patient Name: ________________________________ DOB: ________________

Phone Number: ________________________________ Email: ________________________

Address: ____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize and direct Complete Family Medicine, a service of Hannibal Regional Healthcare System, Inc. (“CFM”) to disclose all or part of my medical record to my anticipated payor which could be my employer, insurance company/ies, the Health Care Financing Administration, Medicare, Medicaid and its or their related agents as necessary to verify or process claims for insurance and third party payment. CFM may also release information as required by applicable law or as necessary or helpful for continuation of my care which includes participation in health information exchanges. I also understand my healthcare information will be aggregated into a health tool for data analysis, health registries and quality improvement opportunities.

AGREEMENT TO PAY

In consideration for services provided, each of the undersigned (including the patient, their spouse, person signing as patient’s representative, and / or parent or guardian of unemancipated minor) agrees to pay all charges of CFM, its clinicians and independent contractors. Each bill is due upon presentation or mailing to the patient or any of the undersigned. If any bill becomes delinquent, the undersigned agrees to pay all collection agency and attorneys’ fees and court costs and other costs of collection. If suit is filed to collect, it may be filed in the county where this agreement was signed.

INSURANCE ASSIGNMENT AND CONSENT TO TREATMENT

The undersigned hereby assigns all monies payable or to be paid by any insurance company/ies, individuals, corporations or any source whatsoever for services rendered to the patient named below to CFM.

I request and consent to receive treatment from CFM. I understand CFM is staffed by a healthcare team which may include physicians, assistants, nurse practitioners, nurses and technicians. I freely accept care from this team and acknowledge the establishment of the provider−patient relationship. I understand this healthcare team will provide information and/or care; however, I maintain the right to make all decisions about my care. This consent is to remain in effect until revoked by me in writing. I understand I have the right to revoke this consent at any time.

ELECTRONIC COMMUNICATIONS

By initialing,

_____ I consent to CFM contacting me for quality improvement measures by phone, text or email.

_____ I consent to CFM contacting me for collection matters by text.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND PATIENT RIGHTS AND RESPONSIBILITIES BROCHURE

I acknowledge I have received a copy of CFM’s Notice of Privacy Practices and the Patient Rights and Responsibilities Brochure. These notices describe how my health information may be used or disclosed and my rights and responsibilities as a patient. I understand I should read them carefully. I am aware the notices may be changed at any time and that I may obtain a revised copy by contacting CFM.

I certify I understand and agree to the provisions contained in this agreement.

Patient Signature: ____ Date of Signature: ________________

Witness: ____ Witness’ Printed Name: ____________________________________

If not signed by the patient, please confirm:

Name: ____ Relationship to Patient: ____________________________________

Address: ____ Phone: ____

HIPAA DISCLOSURE

____ Do Not Release My Health Information. _____ Release My Health Information as follows:

CFM does not require you to complete a HIPAA authorization as a condition for treating you. This authorization is voluntary unless the specific nature of the healthcare is to create information for disclosure (such as an employment physical or independent insurance exam). I understand I have the right to revoke this authorization at any time by submitting written notice, except for any action already taken in reliance on the authorization. I also understand any disclosure I allow may be subject to redisclosure by the recipient and no longer be protected by HIPAA. If I do not revoke this authorization, it will expire in one year from signature. I authorize the disclosure and use of my protected health information to the extent necessary to allow my designated others to discuss my issues when I need help understanding those issues; to pick up medications, prescriptions or results; or to make or manage appointments. It also allows the individual to bring the patient to appointments and consent to treatment. This consent does not grant full access to my medical records.

Name: ____ Phone: __________________________ Relationship: ___________________

Name: ____ Phone: __________________________ Relationship: ___________________

Signature if authorizing Health Information Release: ______________________________________ Date: _______________________