SRMC
SOUTHSIDE REGIONAL
PHYSICIANS NETWORK

Office Use Only
Place Label Here

AUTHORIZATION TO RELEASE INFORMATION

Please contact me at (check all that apply): ☐ Home ☐ Work ☐ Cell

May we leave a message for you at your home? ☐ Yes ☐ No

May we leave a message on your home answering machine/voicemail? ☐ Yes ☐ No

May we leave a message on your cell phone? ☐ Yes ☐ No

I authorize my doctor or nurse to release any medical information to and/or discuss billings issues with the following people:

Name: Relationship:

Home Phone: Cell Phone:

Name: Relationship:

Home Phone: Cell Phone:

I understand that I have the right to revoke this authorization, in writing, at any time by giving notice of my revocation to the Privacy Office, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire when I am no longer a patient. I understand that information disclosed as a result of this authorization may be subject to disclosure by the recipient and may no longer be protected by federal or state law. Southside Physicians Network may not condition treatment, payment, enrollment or eligibility for benefit on whether I sign this authorization.

Signature of Patient or Responsible Party: Date:

At this time I do not want release of information to any other party.

Signature of Patient or Responsible Party: Date:

All Patients - Notice of Privacy Practices, Assignment of Benefits, Payment Policy & Consent to Treat

Required pursuant to Health Insurance Portability and Accountability Act of 1996 (HIPAA), I acknowledge that I have received a copy of the Facility's Notice of Privacy Practices that provides information about how the facility may use and disclose my protected health information. I hereby assign to Southside Physicians Network any insurance or other third-party benefits available for health care services provided to me. I understand that Southside Physicians Network has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Southside Physicians Network, I agree to forward Southside Physicians Network all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt. I have read and understand the payment policy of Southside Physicians Network and agree to abide by the policy. I hereby voluntarily consent for treatment. I permit the facility and its employees, physicians and all others involved with my care to treat me in ways they judge to be beneficial to me. I have the right to ask questions and to receive information about my care and treatment. I consent to examinations, blood tests (including blood tests for communicable diseases such as hepatitis and HIV/AIDS when healthcare personnel have been exposed to my blood and/or body fluids), laboratory and imaging procedures, medications and other services or treatments rendered by my physician and his/her associates. I am aware the practice of medicine is not an exact science and further understand that no guarantee has been or can be made as to the results of the treatments, care or examinations in the facility.

Signature of Patient/Legal Guardian:

Date:

Official Use Only

Verbal Permission Obtained By: Date:

Verbal Permission Obtained By: Date: