Family First Health Care Yale-Lexington
Authorization, Release and Waiver

1. **AUTHORIZATION FOR MEDICAL AND THERAPEUTIC TREATMENT** – Permission is granted to the physician(s) in charge of the care of PATIENT to administer, supervise and order any services that may be deemed advisable in the diagnosis and/or treatment of this case. No guarantees have been made to PATIENT regarding the results of such care and treatment which are hereby authorized.
2. **AUTHORIZATION TO PERMIT PAYMENT OF HEALTH INSURANCE BENEFITS TO HOSPITAL AND PHYSICIANS** – Family First Health Care and PATIENT'S attending physician(s) are authorized to release medical or other information related to outpatient, inpatient and emergency care, including any alcohol, drug or mental health records. HIV infection, AIDS and AIDS-Related Complex (ARC) records to Medicare, its intermediaries. Medicaid, Blue Cross or any commercial insurers from which PATIENT may be entitled to health insurance benefits as may be necessary for Family First Health Care and involved physicians to receive payment for services. Authorized insurance benefits are assigned to Family First Health Care and, as applicable, physician specialists, such as radiologist, pathologists, etc. Family First Health Care is further authorized to assign appropriate portions of such benefits to practitioners for whom Family First Health Care is authorized to bill. The undersigned acknowledges responsibility and agrees to pay in full all remaining balances of unpaid charges due to deductibles, co-insurance or absence of insurance benefits. Family First Health Care is authorized to release any information required in order for an outside credit agency to collect his amount.
3. **AUTHORIZATION FOR RELEASE OF INFORMATION** – I hereby authorize Family First Health Care and/or treating physician to furnish all insurance companies any information which they may request, including photocopies from my medical records as necessary for completion of my claim, or as may be required by law for this treatment.I further authorize Family First Health Care and/or treating physician(s) to furnish information from my medical records pertaining to this treatment as requested by other physicians or medical care facilities such as extended care facilities, intermediate care facilities, hospitals, or home health agencies for my continued care and treatment.
4. **RELEASE OF RESPONSIBILITY FOR SERIOUS DISEASE** – Pursuant to P.A. 488 of 1988 and P.A. 419 and 420 of 1994, I may be tested for Human Immunodeficiency Virus (HIV), Hepatitis B Virus (HBV), Hepatitis C Virus (HBCV) if a health care professional, employee of Family First Health Care, police officer, firefighter, individual licensed under section 20950 or 20952 or other individual who assists in my care sustains a percutaneous, mucous membrane or open wound exposure to my blood or body fluids.
5. **ACKNOWLEDGMENT OF PRIVACY PRACTICES** – Family First Health Care's Notice of Privacy Practices provides information about how protected health information about me (the patient) – including information about Human Immunodeficiency Virus (HIV), AIDS-Related Complex (ARC) and Acquired Immunodeficiency Syndrome (AIDS): including substance abuse treatment records protected under the regulations in 42 Code of Federal Regulations. Part 2, if any; and psychological and social services records, including communications made by me to a social worker or psychologist (if any) – may be used and disclosed. I have been offered an opportunity to review the Notice before signing this consent. I understand that the terms of the Notice may change and that I may obtain a revised copy by contacting the Privacy Officer listed in the Notice. I understand that I have the right to request restrictions on how my protected health information is used or disclosed for treatment, payment or health care operations. My physicians and the facility are not required to agree with this restriction, but if they agree, they will be bound by the agreement.

By signing this form, I acknowledge that I have been offered and/or received Family First Health Care's Notice of Privacy Practices.

_____	_____
Telephone Permission By	PATIENT Signature (Parent/Guardian, if Minor)
_____	_____
Date/Time	Insured Signature (If Different from Above)
_____	_____
Witness	Relationship to PATIENT
_____	_____
2nd Witness (Permission By Telephone)	Witness