Fields' Family Care

96 Tara Commons Dr, Loganville, GA 30052

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMTATION

Patient Name: _____ DOB: _____

I, the undersigned, **authorize permission** for David A. Fields, MD, Family Care, PC to be able to discuss my medical health information with the following individuals (family members or friends):

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Pharmacies for today's RX:

(Local) _____

(Mail Order) _____

I authorize Dr. David A. Fields' office to send un-encrypted emails to me, upon my request:

Email: _____

I hereby authorize the release of any medical information, including information related to psychiatric care, drug and alcohol abuse and HIV/AIDS confidential information, necessary to process insurance claims or any medical information that is required for my healthcare related utilization review or quality assurance activities. I hereby assign and authorize payment to David A. Fields, MD, Family Care PC, of all medical and/or surgical benefits, including major medical benefits to which I am entitled to under any insurance policy or policies, under and self-insurance program, or under any other benefit plan. I understand and acknowledge that this assignment of benefits does not relieve me of my financial responsibility for all fees and charges incurred by me or anyone on my behalf and I hereby accept such responsibility, including, but not limited to, payment of those fees and charges not directly reimbursed to David A. Fields, MD, Family Care PC, by any insurance policy, self-insurance program or other benefit plan. This authorization shall remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered effective and valid as the original. I understand that I have the right to receive a copy of this authorization. **I understand that an increase of 40% shall be added to any balance that is turned over to a collection agency. I understand that I will be charged a $25 fee for No Shows on appointments scheduled.** I, the undersigned, have had the opportunity to review a copy of David A. Fields, MD, Family Care, PC's Notice of Privacy Practices.

Signature: _____ Date: ____/____/____

Patient / Patient Guardian