

Fiel Family & Sports Medicine

PATIENT NAME: _____ DOB: _____ DATE: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Fiel Family & Sports Medicine follows the guidelines as stated in our Notice of Privacy Practices. Please acknowledge by signing below that you have been provided a copy of **Fiel Family & Sports Medicine's** Notice of Privacy Practices.

Patient Signature: _____ **Date:** _____

AUTHORIZATION FOR MEDICAL RECORDS

I authorize the release of photocopies of the following medical records and/or x-ray films in the possession or control of Fiel Family & Sports Medicine, its employees and/or agents FOR THE PURPOSE HEREOF, "MEDICAL RECORDS" AND "XRAY FILMS" SHALL INCLUDE ALL CONFIDENTIAL HIV-RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-661), CONFIDENTIAL COMMUNICABLE DISEASES RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-661), CONFIDENTIAL ALCOHOL OR DRUG ABUSE RELATED INFORMATION (AS DEFINED IN 42 (FR SECTION 2.1 ET SEQ.), AND CONFIDENTIAL MENTAL HEALTH DIAGNOSIS/TREATMENT INFORMATION.

I authorize release of medical information to the entities and through the means indicated below. I understand that confidentiality cannot be guaranteed.

Physicians:
Family Members (please list name and relationship):
Personal Electronic Devices: Voicemail/Answering Machine: YES NO Fax: Yes No (if yes, fax number) _____ Email: Yes No (if yes, address) _____

Patient Signature: _____ **Date:** _____

ASSIGNMENT OF BENEFITS/FINANACIAL AGREEMENT

I authorize release of all medical information that is pertinent to my medical care and necessary to process my insurance claims. I assign all medical and/or surgical benefits including major medical benefits to which I am entitled to **Fiel Family & Sports Medicine**. This assignment will remain in effect until revoked by me in writing. A photocopy if this assignment is to be considered as valid as the original.

I understand that I am financially responsible for all charges. In the unfortunate event that an account is given to a collection agency or to an attorney, for collection, then the patient/responsible party shall pay to **Fiel Family & Sports Medicine** all costs of collection, including reasonable attorney's fees and court costs, in addition to other amounts due **Fiel Family & Sports Medicine**. I have read this information and agree with this policy.

Patient Signature: _____ **Date:** _____