ASSOCIATED ENDOCRINOLOGISTS

HIPAA & INSURANCE RELEASE OF INFORMATION ACKNOWLEDGEMENTS

Patient Name: _________________________________ Date of Birth: ___-___-_______

I authorize Associated Endocrinologists to release my/my child's medical information to my insurance company as necessary for the payment of benefits. I also authorize my insurance company to pay benefits directly to my care provider. These authorizations remain valid and effective until revoked in writing. I also realize that I am responsible to pay any non-covered services.

Signature of Patient or Parent/Guardian: ____________________________________ Date: ______________

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I hereby give my permission to provide my/my child's healthcare information (subject to the exceptions listed, if any) with the following individuals:

Name: ______________________________ Relationship: ______________ Phone: (_____) ______________

Exceptions: *(if none, please write "none")* ____

Name: ______________________________ Relationship: ______________ Phone: (_____) ______________

Exceptions: *(if none, please write "none")* ____

Name: ______________________________ Relationship: ______________ Phone: (_____) ______________

Exceptions: *(if none, please write "none")* ____

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I hereby give my permission to leave detailed medical information on voicemail or on an answering machine.

Please initial: Yes __________ No ___________ Date: ________________

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My signature below acknowledges that I have received and reviewed the "PATIENT NOTICE OF PRIVACY PRACTICES" from Associated Endocrinologists *(a division of Michigan healthcare professionals)*

Signature of Patient/Guardian Date

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DOCUMENTATION OF REFUSAL OR INABILITY TO PROVIDE SIGNED ACKNOWLEDGMENTS:

On ______________, _____________________________________ presented this acknowledgement of receipt
(today's date) (name of AEG representative)

and review of "PATIENT NOTICE OF PRIVACY PRACTICES" to ____
(name of patient/parent/guardian)

The patient/parent/guardian refused ________ or was unable to provide ________ a signature when requested.

Signature of AEG Employee Date

Signature of AEG Practice Manager Date