CLINTON COUNTY MEDICAL CENTER
1005 S. US 27, St. Johns, MI 48879
Ph: 989-224-3000 ~ Fax: 989-224-1424

AUTHORIZATION TO RELEASE INFORMATION, TREATMENT OF A MINOR, AND ASSIGNMENT OF BENEFITS

I understand that as part of my health care, this organization originated and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment.

I authorize Clinton County Medical Center to bill and release to private insurance carriers such information from my patient records as is required in order to receive reimbursement for any billings for services. This includes alcohol and drug abuse and mental health treatment information protected under the regulations in title 42 or code of Federal Regulations Part II. Information about human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS), and AIDS related complex (ARC) as defined by the Department of Public Health rules Act 174 1989 and Act 368 Public Act 1978.

I request that payment of authorized benefits (if billed by the office) be paid directly to Clinton County Medical Center on my behalf. This is an authorization agreement, until such time as revoked by me and a yearly update is required. I understand that I am responsible for/hereby accept responsibility for the payment to Clinton County Medical Center for whatsoever sums of money shall become due and payable for services received. I authorize the provider to initiate a complaint to the insurance commissioner for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials. I certify that all statement made on this application are true.

I authorize Clinton County Medical Center staff to discuss my medical and billing information with the following person(s): (This may include family members, friends, neighbors, or anyone else you designate):

Name & Phone number (if possible)	**Relationship to patient**	**Info to be released (Please circle)**
		Medical, Financial, Mental Health, or all
		Medical, Financial, Mental Health, or all
		Medical, Financial, Mental Health, or all

★_____ _____ _____
Signature of Patient or Legal Representative Date Initials of Witness

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