CCMC
PATIENT CENTERED HEALTHCARE

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.

We may use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that is involved in your care and treatment. For example, we would disclose your protected health information, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose protected health information to other healthcare providers who may be involved in your care and treatment. We may also call you by name in the waiting room when your healthcare provider is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding you care. Also, we may contact you to provide information about health related benefits and services offered by our office.

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 Medical | Financial | Mental Health | All
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Signature of Patient or Legal Representative Date Initials of Witness

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