Parkcrest Orthopedics, LLC
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OPEN AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

PATIENT NAME: _____ DOB: _____

I hereby authorize Parkcrest Orthopedics to release any and all protected health information maintained in my medical records to the following individuals upon their request, concerning my status as a patient, treatment or payment of services provided by Parkcrest Orthopedics.

NAME RELATIONSHIP TO PATIENT

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This authorization is given freely with the understanding that this authorization is valid until revoked by law. I may revoke this authorization at any time, except where information has already been released. Individuals not listed on this form will be unable to receive any information. Parkcrest Orthopedics and its workforce are hereby released from any legal responsibility or liability for disclosure of any of my Protected Health Information as indicated and authorized herein.

NOTICE OF PRIVACY PRACTICES

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information. **I understand** that Parkcrest Orthopedics, LLC may use or disclose my protected health information for treatment, payment or health care operations—which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization. Parkcrest Orthopedics, LLC has a detailed document called the ***'Notice of Privacy Practices'***. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information. **I understand** that I have the right to read the *'Notice'* before signing this agreement. If I ask, Parkcrest Orthopedics, LLC will provide me with the most current *Notice of Privacy Practices*. **My signature** below indicates that I have been given the chance to review such copy of the *Notice of Privacy Practices*. My signature means that I agree to allow Parkcrest Orthopedics, LLC to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Parkcrest Orthopedics, LLC has taken action relying on this consent.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

-I authorize payment of benefits, as determined by Parkcrest Orthopedics, directly to Surgeon/Physician.
- I understand that Parkcrest Orthopedics has a 24 hour cancellation/rescheduling policy and if I am unable to give at least 24 hours notice prior to cancelling, rescheduling, or missing my appointment I may be charged a no-show fee of $25.00.
- I understand I may still be responsible for any amounts not paid by my Insurance Company in the event that the charges made are not reasonable and customary. I understand that in the event of non-payment, I will be responsible for any collection and legal fees associated with the collection of the balance due. The collection fee is 25% of the total balance and this will be added to the account if it is turned over to an outside agency.

By signing below I attest that I have read & understand the above policies of Parkcrest Orthopedics, & accept my responsibility as stated in those policies. I authorize release of information necessary for my insurance company to process my claim.

_____
PRINT NAME

_____
PATIENT'S SIGNATURE (OR PARENT OR LEGAL GUARDIAN IF A MINOR) DATE