RECORDS RELEASE: I hereby authorize the release of any information, including medical and billing information to my insurance company or other party responsible for payment, and other providers involved in my care. Our practice may use and disclose your protected health information for research purposes in certain circumstances unless refusal to do so is provided in writing.

ASSIGNMENT OF BENEFITS: I hereby authorize payment of medical benefits to *Specialists in General Surgery* for services rendered to myself and/or dependents. I understand that I am financially responsible for payment of co-pays, co-insurance, deductibles, and all other charges not covered by my insurance plan.

MEDICARE AUTHORIZATION: I request that payment of authorized Medicare benefits be made to me or on my behalf to *Specialists in General Surgery* for any services furnished me by that physician/clinic/supervisor. I authorize any holder of hospital or medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original.

PATIENT PRIVACY NOTICE:
I acknowledge receipt of the Specialists in General Surgery, Ltd. Notice of Privacy Practice Brochure.

PROVIDER RECORD LOCATOR: A health record locator service helps your health care provider determine where you have received care.

I consent to *Specialists in General Surgery* and my providers to access my information in a record locator. I also consent to *Specialists in General Surgery* and my providers making my information available in a record locator to be searched by other health care providers that may provide me care and treatment.

If you **DO NOT** want *Specialists in General Surgery* to utilize a record locator for **accessing** your health information, you must check this box. ☐

If you **DO NOT** want *Specialists in General Surgery* to utilize a record locator for **sharing** your health information, you must check this box. ☐

Patient Name (print): _____

Signature: _____

Date: _____