

Mountain Health Services, P.C.
Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of the Notice of Privacy Practices Health Insurance Portability and Accountability Act.

I hereby give my permission for my Provider or his/her staff to discuss my medical information re: results/treatments, billing, or related information with the following person/persons listed below:

Patient's Full Name

Signature of Patient or Patient Representative

Date

I am aware that I may change the above authorization with a written request at any time. The new authorization will only become effective once a written request is received by Mountain Health Services.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIANS:

I hereby authorize payment directly to the Physician of the Surgical and Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services.

Signature (Patient or Responsible Person if minor)

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize the Physician to release any information acquired in the course of my treatment to process Insurance claims.

Signature (Patient or Responsible Person if minor)