THE INFORMATION ON THIS SHEET IS TRUE AND CORRECT

I hereby apply for treatment by the physicians of this practice and/or their assistants. I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf and I assign the benefits payable to which I am entitled, including Medicaid, private insurance, or other health plans, to this practice. I understand it is my responsibility to pay any copayment, deductible, or co-insurance amount and that I am financially responsible for all charges whether or not paid by said insurance.

I hereby authorize Children's Medical Group to release and receive my health information for evaluation and treatment of care.

Children's Medical Group, P.C.'s Notice of Privacy Practices is available at www.cmg-pc.com. A hard copy will be provided upon my request.

I hereby agree to payment of an Annual Administrative Fee of $10.00, per individual patient, if any forms need to be completed.

Children;s Medical Group, P.C. has permission to take/store my photo in their Electronic Medical Record (EMR) system for identification purposes.

SIGNATURE: **DATE:**

Due to privacy concerns and regulations, no video recording, photographing, and/or audio recordings are allowed in our offices. This is in line with our policy of securing the privacy and protection of our patients and staff.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO FAMILY MEMBERS

Many of our patients allow family members such as their parent(s), grandparents, guardians or others to call and discuss medical information, request prescriptions, vaccine information, medical records, results of tests, pick up forms, etc. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's written consent. If you wish to have any of your medical information released to family members you must fill out and sign this form. Signing this form will only give consent to release said information to the individuals indicated below.

I, _____, Date of Birth _____ ,
(Print your Name)

Authorize representatives of Children's Medical Group, P.C. to share and/or release information to:

1) _____ Relationship _____

Check all that apply:

O Regarding appointment, time & date O Discuss lab results O Discuss vaccines
O Discuss medical care, an issue or concern O Request and pick up/fax prescriptions/forms

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2) _____ Relationship _____

Check all that apply:

O Regarding appointment, time & date O Discuss lab results O Discuss vaccines
O Discuss medical care, an issue or concern O Request and pick up/fax prescriptions/forms

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3) _____ Relationship _____

Check all that apply:

O Regarding appointment, time & date O Discuss lab results O Discuss vaccines
O Discuss medical care, an issue or concern O Request and pick up/fax prescriptions/forms

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I understand that I have the right to change this authorization, in writing, at any time by sending a written notification to this office.

_____ _____
Patient Name (Print) **Date**

_____
Signature of Patient

If you think we may have violated your privacy rights or you disagree with any action we have taken with regard to your health information we want you, your family or your guardian to speak with us. If you complain to us, your care will not be affected in any way. It is our goal to give you the best care while respecting your privacy.

Children's Medical Group, P.C.
Management