Doylestown Health
Physicians

## AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient's Name: _____ Date of Birth: _____

Home Phone Number: _____ Mobile Phone: _____

Address: _____

Release Records **to** practice(s):

_____

Release Records **from** practice(s):

_____

Information and Dates to be Released:

_____

_____

These Records are Needed: ____ For Personal Use ____ For Continuation of Care

**I understand that:** My medical record may contain information of a sensitive or extremely private nature, including, but not limited to, a history of substance abuse, psychiatric or psychological disorders, abnormal test results, various prescriptions, results of HIV testing, history of sexually transmitted diseases, history of diseases transmitted by intravenous drug use or other high risk behavior, hospitalizations, surgeries, and any other medical or psychological disorder for which I may have been treated.

a) This authorization may be revoked/ modified at any time by writing to Doylestown Health Primary Care except to the extent that information has already been disclosed. If information has already been disclosed in reliance on this authorization, revoking it will only prevent future disclosure.
b) The hospital will not condition treatment, payment, enrollment or eligibility on the provision of this authorization.
c) Information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by federal privacy regulations.
d) I understand that I cannot be compelled to authorize release of any of my medical records.

_____ This authorization expires on _____(*Date*) _____ This authorization has no expiration date

_____ _____
Patient Signature Date

If person signing is someone other than the patient:

_____ _____
Signature Date

_____
Print Name

_____
Relationship to patient **and** authority to sign (e.g., legal guardian, Power of Attorney)

# DOYLESTOWN HEALTH PHYSICIANS

1. **ASSIGNMENT OF BENEFITS:** I hereby assign to Doylestown Health Physicians all benefits payable to me for my care and/or treatment.

2. **FINANCIAL AGREEMENT:** I agree to be responsible for charges not covered by insurance. In consideration of the service to be rendered, I acknowledge the obligation to pay Doylestown Health Physicians in accordance with its regular rates and terms, and if the account is referred to an attorney or agency for collection, to pay reasonable attorney's fees and collection expenses. I acknowledge that I am responsible for any copay and coinsurance at the time of service. I understand that Doylestown Health Physicians reserves the right to charge a fee for any checks returned for non-payment. I understand that the obligation to pay Doylestown Health Physicians may not be deferred for any reason, including pending legal action against other parties to recover medical costs.

3. **CONSENT FOR TREATMENT:** I understand the medical care I will be receiving will be ordered and directed by my physicians or their designees as is necessary in their judgment. I consent to all appropriate examinations and diagnostic or therapeutic procedures to treat conditions found during my examination, including any necessary anesthesia. After the procedure or examination is explained to me, including its risks, benefits and alternatives, I will have the opportunity to ask any questions and have them answered to my satisfaction.

4. **PHOTOGRAPHS:** I understand and agree that my examination and treatment may include taking of photographs for clinical and educational/teaching purposes. If photographs are used for my treatment, they will become part of my medical record. If used for educational/teaching purposes, photographs will not contain personal identifiers.

5. **"GOOD FAITH ESTIMATE":** You have the right to receive an explanation of how much your medical care will cost. Under the law, health care providers must give **patients who don't have insurance or who are not using insurance** an estimate of the bill for medical items and services.

    - You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like tests, medication, equipment, and hospital fees.
    - Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service. You can also ask your provider, and any other provider you choose, for a Good Faith Estimate before you schedule a service.
    - If you received a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.
    - Make sure to save a copy or a picture of your Good Faith Estimate.

6. **FINANCIAL ASSISTANCE:** If you are unable to meet your financial obligation, financial counselors are available to assist you. Please call 267-370-5285 for more information.

7. **CONSENT TO CONTACT:** If, at any time, I provide a telephone number (including cell phone), email address or similar electronic means to communicate with me, I consent to receive such communications (including autodialed calls and prerecorded messages) from Doylestown Health Physicians, its affiliates, employees, agents and independent contractors, including collection agents regarding the services rendered and/or my related financial obligations.

8. **FOR MEDICARE PATIENTS:** I certify the information I have provided in applying for payment under the Title XVIII of the Social Security Act is correct. I am aware that I may incur a coinsurance liability for outpatient service(s) provided by Doylestown Health Physicians as well as the hospital.

9. **HIPAA:** I acknowledge that Doylestown Health's Notice of Privacy Practices has either been provided or made available to me.

_____

Signature of Patient/Authorized Representative Date

_____

**By signing above, I hereby acknowledge that I have read this form and have had the opportunity to ask questions and have them answered.**

_____

Signature of Witness Date