Auburn Medical Group, Inc.

Acknowledgment of Receipt of Summary of Notice of Privacy Practices and Advanced Directive Information and Medicare Questionnaire

- Are you covered by any group health plan based on current or former employment?____Yes____No. If so, how many employees work for the employer providing coverage?_____

- Are you covered by any group health plan based on a family member's current or former employment?____Yes____No. If so, how many employees work for the employer providing the group health plan?____

- Are you receiving Federal Black Lung Program Benefits?____Yes____No

- Is the illness or injury due to a work-related accident or condition, and is it being covered by workers compensation?____Yes____No

- Is the illness or injury covered under automobile insurance, no-fault insurance, medical payments coverage, personal injury insurance, liability insurance, or a medical "set aside" account form a legal settlement?_____Yes_____No

- Are you being treated for an injury or illness for which another party could be held liable?_____Yes_____No

Use and disclosure of protected health information is regulated by a federal law known as The Health and Insurance Portability and Accountability Act of 1996 (HIPAA).
Under HIPAA, providers of healthcare are required to give patients their Notice of Privacy Practices for Protected Health Information and make a good faith effort to obtain a written acknowledgment that this notice was received.

Therefore, I acknowledge that **Auburn Medical Group, Inc.** has provided a written copy of their Notice of Privacy Practices.

ASSIGNMENT OF BENEFITS – MEDICAL RELEASE

I hereby authorize the Auburn Medical Group, Inc. to release to my insurance company any information required in the course of the examination and/or treatment. I also authorize my insurance company to pay directly to the practice of Auburn Medical Group, Inc. any benefits due. I understand payment is my obligation regardless of insurance or other third party involvement. This authorization shall expire upon notice. I permit a copy of this authorization to be used in place of the original. I grant permission to view prescribing information from external sources.

I have received information regarding Advanced Directives.

Please list below any individuals to whom you would authorize disclosure of health information.

1. _____ Relationship: _____

2. _____ Relationship: _____

3. _____ Relationship: _____

4. _____ Relationship: _____

**If you are signing as a personal representative, documentation of your legal right to do so must be provided.*

_____ _____
Signature of Patient or Personal Representative Date

_____
Relationship to Patient