Auburn Medical Group, Inc.

Acknowledgment of Receipt of Notice of Privacy Practices, Assignment of Benefits, and Advanced Directive Information

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 to me.

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 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 my prescribing history 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

_____ _____
Printed Name Relationship to Patient