Alliance Medical Associates, PLLC

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Patient Consent & Authorization Form

This notice describes how medical information about you may be used and disclosed and how you can get access to this information please read carefully.

We are committed to protecting the privacy of the information you provide to us regarding your health information under the (HIPPA) Health Insurance Portability and Accountability Act, effective April 14, 2003, I understand by signing this consent, I am authorizing the use and disclosure of my protected health information for:

- Treatment, diagnosing or providing treatment, sending or obtaining medical information from other health care providers involved in your treatment;
- Obtaining payment for your services provided, insurance companies, electronic claims filing or collection agencies; and
- For daily health care operations of our practice.

There are several circumstances where the use and disclosure of your medical information is legal without your consent, complete details are in our notice of privacy, a copy of which is available to you in our waiting room, a copy of which is available to you in our waiting room. Any other uses and disclosures of your medical information will be made only with your written request. We are required to make available for your review or give a copy of our notice of privacy practices, which contains a more detailed description of the uses and disclosures of your protected health information and your rights under HIPPA. We are required to abide by the terms of our notice of privacy practices. We reserve the right to change the terms of our notice at any time and you may obtain the most current copy of this notice.

You have the right to request restrictions on how your protected health information is used and disclosed. You may also revoke this consent at any time. Any restriction, revocation or complaint of your protected health information may be done in writing to our privacy officer, Sonia Sweat. However, any use or disclosure that occurred prior to the date of this consent is not affected.

I hereby authorize Alliance Medical Associates, PLLC to furnish information to my insurance carriers concerning my illness and treatment, and I assign Alliance Medical Associates, PLLC payment for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by the insurance company.

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Patient Signature **Date**

Revised 01/30/2012