Patient Name (print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize payment of medical benefits by the insured directly to LM Chadfield DO PLLC. I also request payment of government benefits directly to the party who accepts assignment. I understand that I am financially responsible for payment of all services or materials provided to myself that are not a covered benefit under my insurance. I agree to pay all services within 30 days unless a payment plan is negotiated in advance. I authorize LM Chadfield DO PLLC to release any information required to process my claim. This request shall remain in effect until revoked by myself in writing.

**Authorization for Specific Confidential Communications**

I authorize my physician and/or administrative and clinical staff to disclose the following protected health information to:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone No. ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell No. ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work No. ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone No. ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell No. ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work No. ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Select the Protected Health Information (PHI) to be used or disclosed to the above listed individual(s) from the list below**

* Medical Care/ Treatment: Yes\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_
* Can a message be left on your answering machine/voicemail Yes\_\_\_\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Names of the nearest 2 relatives (at least one with whom does NOT live with)**

**and whom we may contact in case of an emergency.**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell No.( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work No.( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell No.( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work No.( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This authorization shall be in force and effect and does not expire until it is revoked in writing. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice’s Privacy Contact at: 1025 Spaulding Ave. SE Suite B, Grand Rapids, MI 49546. I understand that a revocation if not effective to the extent that my physician has relied on the use or disclosure of the PHI or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. By signing below, I acknowledge that I have been offered a copy of this office’s Notice of Privacy Practice Form.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Parent Guardian

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (circle one)