

Patient Name \_\_\_\_\_

**CONSENT FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

\_\_\_ Kelly P. Coffey DO PC      \_\_\_ John A Sauchak DO PC      \_\_\_ Michael P Swords DO PLLC  
\_\_\_ Mark L Davis DO PC      \_\_\_ David A. Shneider MD PC      \_\_\_ Courtney Estala PA  
\_\_\_ Meredith H Fabing DO PC      \_\_\_ Kenneth E Stephens PhD DO PC

I authorize this provider to release to any third party payer, or its representative, which may be responsible for payment in my case, or as required by law, such information from my medical record as is necessary in order to receive reimbursement for any billings rendered relating to my treatment, including alcohol and drug abuse records protected under the regulations in 42 CFR, Part 2, if any, and information about communicable disease and infection as defined by Department of Public Health rules(Michigan Public Health Code 1988 Public Act 488) which include venereal disease, tuberculosis, human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS).

**\*Signature:** \_\_\_\_\_  
(Patient or Legal Representative)

**RECEIPT OF NOTICE OF PRIVACY PRACTICES**

By signing below I acknowledge that I have reviewed and/or received a copy of this office's Notice of Privacy Practices.

**\*Signature:** \_\_\_\_\_  
(Patient or Legal Representative)

**FINANCIAL RESPONSIBILITY**

I understand that I am financially responsible to pay deductibles, co-insurance or any other balance not paid by my insurance.

**\*Signature:** \_\_\_\_\_  
(Patient or Legal Representative)

**MEDICARE PATIENTS**

**ASSIGNMENT OF BENEFITS: MEDICARE PATIENTS**

I request that payment of authorized Medicare and Medigap benefits be made on my behalf to this provider for any services furnished to me. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

I request that payment of authorized Medigap benefits be made either to me or on my behalf to this provider for any services furnished to me by this provider. I authorize any holder of medical information about me to release to my Medigap insurer any information needed to determine these benefits or the benefits payable for related services.

Medicare ID# \_\_\_\_\_

Name of Medigap/Supplemental Carrier \_\_\_\_\_

**\*Signature:** \_\_\_\_\_  
(Patient or Legal Representative)