

MURTHY GEDALA PLLC

PATIENT AUTHORIZATION FORM

RELEASE OF MEDICAL INFORMATION	INITIALS
I authorize MURTHY GEDALA PLLC to release or disclose any protected health information about me to facilitate treatment, payment and healthcare operations.	

CONSENT OF TREATMENT	INITIALS
I authorize MURTHY GEDALA PLLC to perform a physical examination and provide me (or the patient I represent) any medical treatment deemed necessary.	

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF INSURANCE BENEFITS	INITIALS
I understand I am ultimately responsible for payment on my account. I understand it is my responsibility to provide current insurance information to MURTHY GEDALA PLLC. I understand I am responsible for any referral or authorizations that my insurance may require and for any charges not covered by my insurance, to include co- payments, deductibles and coinsurance. I authorize payment of benefits to be paid directly to MURTHY GEDALA PLLC. I understand I am financially responsible for any balances and charges not covered by this assignment.	

NOTICE OF PRIVACY PRACTICES	INITIALS
I confirm MURTHY GEDALA PLLC has provided me a copy of the Notice of Privacy Practices which explains how my Protected Health Information (PHI) may be used and/or disclosed.	

Print Patient Name

Signature of Patient or Legal Representative

Date