KEITH D. JORGENSEN, MD, PROF. ASSN.
44 BIRCH STREET, SUITE 304
DERRY, NH 03038

AUTHORIZATION TO RELEASE INFORMATION TO FAMILY/FRIEND

I authorize the physician/provider/surgical facility to release medical information, to include test results or any other medical findings, to family members/friends listed below:

______________________________ Relationship: ______________________________

______________________________ Relationship: ______________________________

Signature: ______________________________ Date: ______________________________

I understand that, under Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information.

Your ***Notice of Privacy Practices*** has been made available to me, containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of this notice.

In accordance with the ***Notice of Privacy Practices,*** I authorize clinical or medical information necessary to process my claim for insurance/disability benefits. I authorize release of clinical or medical information to another medical facility when I am referred (including self referred) for further treatment.

I authorize my Insurance Company(ies), to include third party liability companies, to pay on my behalf such benefits as are covered directly to Keith D. Jorgensen, MD, PA for services rendered, and I understand that I am financially responsible for charges not covered by this assignment, to include services denied due to noncompliance with the terms of my insurance plan, collection costs and any fees incurred for returned checks.

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Patient Name

______________________________ ______________________________
Signature of Patient or Legal Guardian Date

______________________________ ______________________________
Printed Name of Legal Guardian Relationship to Patient

AUTHORIZATION FOR MEDICAL AND/OR SURGICAL TREATMENT OF A MINOR

I hereby authorize the physician/provider in charge of the care of______________________________
To administer and treat as deemed advisable in the case of this patient. I have <u>custody</u> and/or <u>legal</u> responsibility for this patient.
Signature: ______________________________ Date: ______________________________

Relationship to Patient: ______________________________