MIDWAY MEDICAL CENTER, P.A.

AUTHORIZATION
I, the undersigned certify that I (or my dependent) has insurance coverage as listed above and assign directly to Midway Medical Ctr Clyde. I understand that I am financially responsible for all charges whether or not paid by insurance. I remain responsible for payment of co-pays, deductibles, non-covered services, and any other charges not paid by insurance within 30 days. I hereby authorize Midway Medical Center, P.A. to release all information necessary to secure payment of benefits. I authorize the use of this signature for all insurance claims.

X Signature_______________________________________Date__________________

Are you the Guarantor? Yes__ No __ If not please see receptionist.

CONSENT FOR TREATMENT
Having voluntarily presented myself (or my dependent) to Midway Medical Center, P.A., I acknowledge recognition of the fact that the evaluation and treatment received from Midway Medical Center, P.A. is advised and deemed necessary to be the judgment of the Physician.

X Signature_______________________________________Date__________________

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE (HIPPA)
By signing this form, you acknowledge that Midway Medical Center, P.A. has offered or given to you a copy of its Privacy Notice, which explains how your health information will be handled. We must attempt to have you sign this form on your first date of service with us after April 14, 2003. This includes the situation where your first date of service occurred electronically. If your first date of service with us was due to an emergency, we must attempt to give you this notice and get your signature acknowledging receipt of this notice as soon as possible after the emergency.

☐ **I have received or read a copy of the Privacy Notice of Midway Medical Center, P.A.**

☐ **Midway Medical Center, P.A. has offered me a copy of the Privacy Notice which I have declined and has given me the chance to discuss my concerns and questions about the privacy of my health information.**

X Signature_______________________________________Date__________________

CONSENT FOR DISCLOSURE OF PERSONAL MEDICAL INFORMATION
As a patient I agreed to let certain individuals participate in discussions and decisions related to my medical care. Therefore, I hereby authorize the physicians and staff of Midway Medical Center, P.A. to disclose my personal medical information to the following individual(s).
___Midway Medical Center, P.A. may disclose my medical information only in my presence.
___Midway Medical Center, P.A. may disclose my medical information when I am not present; this includes telephone calls, fax or mail.

__I understand that this consent may be revoked by me at anytime by written notice of Midway Medical Center.

Name _______________________________ Relation __________________ Phone ________________
Name _______________________________ Relation __________________ Phone ________________
Name _______________________________ Relation __________________ Phone ________________

__ Person(s) listed above age 18 or older may pick up prescription when I am not present.

X Signature____Date__________________

Witness Signature_____________________________________ Date __________________

The staff of Midway Medical Center should complete this section if Acknowledgement Form is not signed by the Patient:

1. Does the patient have a copy of the Privacy Notice? **Yes__ No __**
2. Please explain why the patient was unable to sign an acknowledgement form and our efforts in trying to obtain the patient signature: ____

Employee Signature: ____________________________________ Date ________________________