Consent for Care and Release Information

This Consent to Release Information is HIPAA compliant. It is intended for the person/persons it is addressed to. If you receive this in error, please shred all copies and discard or return to this office.

I hereby give permission to ***Holly Springs Feeding & Speech*** to obtain and release any and all information about my child concerning his/her care, treatment, evaluation, or billing, pertaining to his/her treatment for the purpose of continuity of care. I agree to allow pertinent medical information to be faxed or verbal consulted to all parties involved with this patient's care.

I understand that I may revoke this Authorization at any time except to the extent that prior action has been taken in reliance on this Authorization. I understand that if I want to cancel/revoke this Authorization, I must mail, fax or bring a letter in person stating that I want to cancel this authorization.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

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.

HSFAS will provide all copies of reports to patients after the evaluation is complete. Please note that to ensure HIPPA compliance, all records must be picked up from the office.

AUTHORIZATION BENEFIT ASSIGNMENT - FINANCIAL RESPONSIBILITY- RELEASE OF INFORMATION

I authorize ***Holly Springs Feeding and Speech, PLLC*** to release to the insurance carrier any information needed for the payment of any claim. I authorize payment to ***Holly Springs Feeding and Speech, PLLC*** from my insurance carrier or third party payer.

I agree to pay any applicable co-payments at the time of service and coinsurance and/or deductibles as agreed between a ***Holly Springs Feeding and Speech, PLLC*** and me. I understand that my insurance benefits may not cover all charges and that I am responsible for those charges not covered by my health insurance or third party payer. I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

Your permission is required to release any information to any other person, except in cases of imminent danger, neglect or abuse as is required by law. You have the right to seek a second opinion or to end the evaluation/treatment at any time.

Patient's Name and Date of Birth: _____

Healthcare Professionals

To/From:

_____Fax_____ Phone #_____
Physician Healthcare Provider

_____Fax_____ Phone #_____
Physician Healthcare Provider

_____Fax_____ Phone #_____
Physician Healthcare Provider

By my signature, I authorize, ***Holly Springs Feeding and Speech, PLLC*** to release all information necessary, including medical records, to secure payment.

_____ _____
Parent/Guardian's Signature / Patient's Signature (if over 18 years of age) Date