HIPAA Release

Assignment of Benefits

I hereby assign payment directly to Hugh Chatham Medical Group of the medical and/or major medical benefits, if any, otherwise payable to me pursuant to the terms of any insurance policy for services rendered.

Release of Information

I hereby authorize Hugh Chatham Medical Group to release such medical and billing information as may be required by any insurance company concerned with payment of benefits for me (or my dependent child). I further authorize Hugh Chatham Medical Group to release medical information to any facility or physician to whom I (or my dependent child) am/are referred. These authorizations shall remain in effect until I provide written notice revoking them. If I (or my dependent) is referred to another physician whose practice is owned or operated by Hugh Chatham Memorial Hospital, I hereby authorize the release of this patient information packet in its entirety.

Privacy Notice

I acknowledge that I have received the Hugh Chatham Medical Group Privacy Notice as required by the Health Portability and Accountability Act (HIPPA).

Insurance Coverage Spouse or Parent

If your insurance coverage is through the employer of your spouse or parent, we must have the policy holder's birth date as well as their social security number in order to file a claim to your insurance company. We apologize for any inconvenience this may cause and appreciate your understanding and compliance with this matter.

Policy Holder's Name: _____

Policy Holder's Social Security Number: _____

Policy Holder's Date of Birth: _____

_____ _____

Signature of patient or responsible party **Date**

150 Parkwood Drive | Elkin, NC 28621
336-527-7000 | HughChatham.org

Hugh Chatham Medical Group
an affiliate of Hugh Chatham Memorial Hospital

HIPAA Release

AUTHORIZATION TO RELEASE INFORMATION TO FAMILY MEMBERS

Under the HIPAA regulations we are not allowed to give any medical or billing information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must complete this form. Signing this form will only give consent to release this information to the family members indicated below.

You have the right to revoke this consent in writing.

I authorize/allow Hugh Chatham Medical Group to release my medical and/or billing information to the following individual(s):

1. _____ Relation to patient: _____ Phone #: _____
2. _____ Relation to patient: _____ Phone #: _____
3. _____ Relation to patient: _____ Phone #: _____
4. _____ Relation to patient: _____ Phone #: _____

Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

AUTHORIZATION TO LEAVE MESSAGES WITH HOUSEHOLD MEMBERS/ANSWERING MACHINE

Occasionally it is necessary to leave messages for patients to remind them of an appointment, to notify the patient that the staff would like to discuss or schedule test results, or to ask a patient to call regarding an issue or concern. At no time will a representative of this office discuss your medical condition without your consent. The purpose of this consent is to leave messages with members of your household or on your answering machine.

You have the right to revoke this consent in writing.

Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

150 Parkwood Drive | Elkin, NC 28621
336-527-7000 | HughChatham.org

Hugh Chatham Medical Group
an affiliate of Hugh Chatham Memorial Hospital