CONSENT FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR PAYMENT, TREATMENT AND HEALTH CARE OPERATIONS

By signing below, you hereby consent for this Practice, (Central Georgia Pulmonary Associates, L.L.C.), to use or disclose information about yourself (or another person for whom you have the authority to sign) that is protected under federal law, for the sole purposes of treatment, payment and health care operations. You may refuse to sign this consent form.

You should read the Notice of Privacy Practices for PHI attached to this form before signing the Consent. The terms of the Notice may change from time to time, and you may always get a revised copy of it by asking the Privacy Officer for this Practice.

You have the right to request that the Practice restrict how PHI is used or disclosed to carry out treatment, payment, or health care operations. The Practice is not required to agree to requested restrictions, however; if the Practice agrees to your requested restrictions, the restriction is binding on it.

Information about you is protected under federal law, and you have the right to revoke this Consent, unless we have taken action in reliance on your authorization (as determined by our Privacy Officer). By signing below, you recognize that the protected health information used or disclosed pursuant to this Consent may be subject to re-disclosure by the recipient and may no longer be protected under federal law.

You may communicate with the following individuals regarding my condition or course of treatment:

_____

You may communicate confidential information to me, including invoices for services, to the following address and/or phone numbers:

_____

_____ _____

Individual Signature Date

As a personal representative, I have authority
to act for the individual because I am the individual's

_____

I, _____, authorize the release of medical information to Central Georgia Pulmonary Associates, L.L.C.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's record. I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance, and all other health plans to Central Georgia Pulmonary Associates, L.L.C.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

BILLING DEPARTMENT PROCEDURE AND AGREEMENT

Please be advised that payment is expected at the time of service. You will be asked to pay your portion, based on your insurance plan specifications. We advise you to review your plan requirements before your visit, so that you clearly understand your responsibility.

I have read and understand the billing procedure of this office.

Signed_____ Date _____