



PROGRESSIVE FAMILY CARE, LTD.  
509 HAMACHER ST – SUITE 103 – WATERLOO, IL 62298

Patient Name \_\_\_\_\_ DOB \_\_\_/\_\_\_/\_\_\_

**IMPORTANT READ CAREFULLY AND SIGN!!!**

**Insurance Release:** I hereby authorize the physicians to release to any party responsible for payment any information acquired in the course of medical information or treatment including but not limited to information regarding psychiatric, HIV, treatment and/or testing. A Photostat of this authorization shall be considered as valid as the original.

**Authorization to Pay Benefits to Physician:** I hereby authorize Progressive Family Care to process and receive direct payment for all Medicare assigned and/or major medical benefits from insurance companies. I recognize my financial obligation to pay any co-insurance, deductible, and non-covered services provided, as required. The policy of this office is that the parent who presents and requests treatment for a child is responsible for all fees associated with the services rendered.

**Signature of Patient, Parent or Legal Guardian X** \_\_\_\_\_ **Date** \_\_\_\_\_

We treat personal and health information securely and confidentially. We limit access to personal information to only those persons who need to know that information to provide services to patients. As required by the Health Information Portability and Accountability Act of 1996 you have a right to request the opportunity to inspect and copy health information that pertains to you. Please see our Privacy Policy posted in the waiting room.

**Signature X** \_\_\_\_\_ **Date** \_\_\_\_\_



## DESIGNATION OF PERSONAL REPRESENTATIVE

As required by the Health Information Portability and Accountability Act (HIPAA) of 1996 you have a right to nominate one or more persons to act on you behalf with respect to the protection of health information that pertains to you. By completing this section you are informing us of your wish to designate the named person as your personal representative. You may revoke this designation at any time by dating and signing the revocation of your copy of this form and returning it to this office.

### **Designation Section**

I, \_\_\_\_\_ (print name) hereby nominate the following person to act as my personal representative with respect to decisions involving the use and/or disclosure of health information that pertains to me.

\_\_\_\_\_ (print name of Personal Representative)

This person is to be afforded all of the privileges that would be afforded to me with respect to my health information.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

### **Revocation Section**

I understand that I may revoke the designation at any time by signing below. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance of this designation.

I hereby revoke the designation of a personal representative.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



**HIPAA PHONE INFORMATION RELEASE AUTHORIZATION**

This consent authorizes PFC to release detailed information including you test results, follow-up recommendations, treatment plans, etc. This information will be shared in detail via voicemail or to person(s) who have access to the numbers you deem acceptable for us to share this information and provide to us below.

Please indicate which number(s) we may leave detailed information:

Home: \_\_\_\_\_ Yes \_\_\_ No \_\_\_

Cell Phone: \_\_\_\_\_ Yes \_\_\_ No \_\_\_

Work: \_\_\_\_\_ Yes \_\_\_ No \_\_\_

Alternate # 1: \_\_\_\_\_ Yes \_\_\_ No \_\_\_

**Signature(patient or rep)** \_\_\_\_\_ **Date:** \_\_\_\_\_

Warning: I understand that if the individual I have authorizes to receive the information is not a health plan or health care provider, therefore, released information may no longer be protected by federal privacy regulations.

Notice of Rights: You may refuse this authorization. You may revoke this authorization at any time. Your revocation must be in writing, signed by you or on your behalf and delivered to PFC. Your revocation will be effective upon receipt. You have a right to receive a copy of this authorization. Treatment, payment, enrollment and eligibility for benefits will not be conditioned on your providing or refusing to provide this authorization.