Pinchot Family Medicine
Signature Authorization Form

Please complete the Authorization Form below. Don't forget to sign the form. **Thank You!**

Patient name ______________________________ Medicare No: ____________________
(Print name and Medicare number exactly as they appear on Medicare card)

I request that payment of authorized Medicare and/or Medicaid benefits be made either to me or on my behalf to ____ or its agent, for any services furnished to me by that supplier. I authorize any holder of hospital or medical information about me to release to the Health Care Financing Administration and its agents and carriers any information or documentation needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original. I understand that this authorization may be used by the supplier for all services in the future until such time as I revoke this authorization in writing.

Patient Signature: ________________________________ **Date** ____________________

If the patient is unable to sign, an authorized representative for the patient may sign.

Representative's Signature: ____________________________ Date __________________

Relationship of representative to the patient: ____spouse; ____son/daughter; ____________
POA; _____ Guardian; ____ Executor; ____ other ______________________________

Representative's Phone Number: ____
Address of Representative: ____
____

If the patient is unable to sign, please document why the patient cannot sign.

Reason Patient is unable to sign: ____
____

All patient health care information is considered confidential. We are required by law to maintain the privacy of confidential health information known as Protected Health Information (PHI). According to the Health Insurance Portability and Accountability Act of 1996, PHI may be made available without your written consent for purposes of treatment, billing, and health care operations including, but not limited to, quality assurance and training. Release of PHI for purposes other than those stated above is restricted to insure protection of your privacy.

Please direct any questions regarding this authorization form or release of PHI to our billing office: 717-502-4149

This form may be mailed to our billing office:

Pinchot Family Medicine
P.O. Box 88
Rossville, PA 17358