TOCA RELEASE OF INFORMATION / ASSIGNMENT OF BENEFITS / HIPAA PRIVACY PRACTICES
Please initial after each line indicating that you have read and understand.

Authorization for Release of Information: I authorize The Orthopedic Clinic Association to disclose all or any part(s) of the patient's medical record to listed insurance companies and any agency conducting reviews concerning Worker's Compensation._____**(Initial)**

***By allowing anyone to accompany you in the exam room to see the physician you are giving TOCA physicians permission to discuss your medical information with them present in the room.* _____(Initial)**

Authorization to E-Prescribe: I understand that my physician may be sending prescriptions and refill medications through an e-prescribing system electronically. I have been informed on the e-prescribing process. I also give permission for The Orthopedic Clinic Association PC to obtain my medication history from the pharmacy, my health plans, and my other healthcare providers. _____**(Initial)**

Assignment of Benefits: I hereby authorize payment directly to The Orthopedic Clinic Association by my insurance company(s). In the event an overpayment is made from more than one insurance company, I understand the overpayment will be sent to the appropriate payer. _____**(Initial)**

Health Insurance Portability and Accountability Act (HIPAA): I acknowledge that a copy of the HIPAA Notice of Privacy Practices was made available to me. I was given the opportunity to view a copy of the Notice, which describes how health information about me may be used, disclosed, and how I can get access to this information. _____**(Initial)**

I CERTIFY I HAVE READ AND FULLY UNDERSTAND ALL OF THE ABOVE INFORMATION TO INCLUDE THE RELEASE OF INFORMATION, ASSIGNMENT OF BENEFITS, E-PRESCRIBING AND PRIVACY PRACTICES.

_____ _____ _____
PATIENT NAME **SIGNATURE (PATIENT/PARENT OR LEGAL GUARDIAN)** **DATE**

PATIENT AND FAMILY MEMBER MEDICAL RECORDS RELEASE FORM

IF YOU MAY WANT A COPY OF YOUR RECORDS IN THE FUTURE, PLEASE COMPLETE THIS SECTION AND SIGN BELOW. YOU WILL NEED TO CALL FOR YOUR RECORDS. THEY WILL NOT BE SENT AUTOMATICALLY.

PATIENT NAME: _____PID#_____

ADDRESS: _____

CITY: _____STATE: _____ZIP: _____

PHONE#: _____FAX #_____E-MAIL:_____

If I call for my records and request, I have agreed to receive electronic communications, such as Email or Fax to the Fax # and Email listed above. I understand that such electronic transmissions may be intercepted or received by the wrong party. I may choose to have all records mailed to the above address.

PLEASE LIST ANY FAMILY MEMBERS YOU WANT TO HAVE VERBAL COMMUNICATION WITH ANY TOCA STAFF AND/OR PHYSICAL ACCESS TO YOUR HEALTH CARE INFORMATION. THIS FORM MUST BE FILLED OUT AND SIGNED TO BE IN EFFECT. IN ORDER TO MAKE ANY CHANGES A NEW FORM MUST BE COMPLETED.

NAME: _____ RELATIONSHIP:_____

NAME: _____ RELATIONSHIP:_____

PATIENTS 18 YEARS AND OLDER, MUST SIGN OWN RELEASE AND MUST LIST PARENTS IF THEY WISH THEM TO HAVE ANY VERBAL COMMUNICATION WITH ANY STAFF OR PHYSICAL ACCESS TO THEIR RECORD

_____ _____ _____
PATIENT NAME **SIGNATURE (PATIENT/PARENT OR LEGAL GUARDIAN)** **DATE**