APEX PHYSICIANS
INFECTIOUS DISEASES SPECIALISTS
7312 E. Deer Valley Road, Suite 100 • Scottsdale, Arizona 85255
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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION AND PAYMENT OF BENEFITS

I HEREBY AUTHORIZE the release of any medical information, including information related to psychiatric care, drug and alcohol use, HIV/AIDS status, or other confidential information , as necessary to process insurance claims, or any other medical information that is required for any healthcare related utilization review or quality assurance activities.

I hereby assign and authorize payments to Apex Physicians of medical and surgical benefits, including major medical benefits, to which I am entitled under any health insurance policy, self0insurance program, or other medical benefit plan.

I understand and acknowledge that this assignment of benefits does not relieve me of my financial responsibility for all medical fees and charges incurred by me or anyone on my behalf and I hereby accept such responsibility, including but not limited to payment of those fees and charges not directly reimbursed to Apex Physicians by any insurance policy, self-insurance program, or other medical benefit plan.

The authorization shall remain valid during my care at Apex Physicians. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that I have the right to receive a copy of this authorization.

By signing below I indicate that I have read and understood the policy described above.

_____

Signature of Patient or Legal Surrogate Date Time

_____

Printed Name of Patient or Legal Surrogate Relationship (if Legal Surrogate)

ACKNOWLEDGEMENT OF HIPAA PATIENT PRIVACY POLICY

I acknowledge that a copy of the office HIPAA patient policy was made available to me and that I had ample time to review the document and ask questions. I also acknowledge that printed copies of this policy are available upon request. I understand that any questions or concerns I have about the privacy policy should be directed to the practice administrator.

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Signature of Patient or Legal Surrogate Date Time