## Ongoing Communication Regarding Your Healthcare

**DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?**

**(Please provide information below)**

For ongoing communication regarding your healthcare and for your privacy, you must complete this section to authorize this Practice to release and/or discuss your health information with the following people or organizations for the following specific dates of service. Any revocation or modification to your authorization with regard to a family member or other individual must be submitted in writing.

From date of service: _____ To date of service: _____

| **Name of person:** | **Address:** | **Phone/Fax:** | **Relationship to you:** |
|---|---|---|---|
| Example: John Doe | 3 Main St., ABC City, SC 29401 | 843-555-1212 | Husband |
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## Authorization, Assignment of Benefits, and Referral Medical Release

I consent to treatment and allow this Practice and their affiliates to use and release my protected health information for treatment, payment, and healthcare operations as allowed by HIPAA and is described in the Carolina Neurological Clinic Notice of Privacy Practices, which a copy has been made available to me.

I understand that my medical information including complete medical records, test results, and billing information may be released to my insurance company and to other medical professionals and/or medical care institutions for treatment and payment purposes.

I allow payment to be made directly to Carolina Neurological Clinic for all medical or surgical benefits otherwise payable to me under terms of my insurance.

I understand that I am financially responsible for all co-payments, co-insurance, deductibles, and non-covered services.

A photocopy of this form shall be considered as effective and as valid as the original.

To the best of my knowledge the information I have given on this form is accurate and true. I know it is my or my legal guardian's responsibility to keep this Practice and my Physician informed of changes to my contact information; failure to do so may interfere with the ability to contact me concerning my healthcare.

**Print Patient's Name:** _____

**Signature of patient or representative:**_____ **Date:**_____/_____/_____

**Description of Representative's Authority:**_____