Gilvydis Vein Clinic

Patient Name: _____

Birth Date:_____ MRN#:_____

Release of Medical Information for Payment of Claims

I consent and request GILVYDIS VEIN CLINIC of Sycamore IL, to furnish my insurance company or third party payor the following specific information contained in my medical records for review, examination and/or photocopies: an insurance claim for and documentation related to billed services which may include chart notes, ancillary test results and procedures.

The purpose of this disclosure is for my insurance company or other third party payor to process payment for my medical service understand that the information provided pursuant to the this release of information may contain mental health, developmental disabilities, alcohol/drug abuse, and/or other Acquired Immune Deficiency Syndrome(AIDS/HIV) information. I understand that authorization allows the aforementioned information to be released orally through copies of medical records.

I understand that if I refuse to sign this release of information, the information will not be furnished (except as required by law), my insurance company or third party payor cannot be billed. In such case, I will be financially responsible for all charges.

This release will remain in effect for one (1) year from the date of signature below. I understand that this release maybe revoked by me at any time. Any revocation must be in writing, signed by me and my signature must be witnessed by a person who can attest my identity. No written revocation of consent shall be effective to prevent disclosure of records and communications until its received by GILVYDIS VEIN CLINIC, and no other revocation will be effective to the extent of GILVYDIS VEIN CLINIC has already action and reliance on it.

Assignment of Benefits

I assign payment of medical benefits to GILVYDIS VEIN CLINIC for services described. I understand that: I am financially responsible for charges not covered plus any and all costs incurred in or related to the collection of such charges. Including but not limites to, reasonable collection agency charges, not to exceed 50% of the principal, attorney's fees, and cost of suit.

Privacy Notice

_____ **I have received GIlvydis Vein Clinic's Notice of Privacy**

_____ **I have been offered Gilvydis Vein Clinic's Notice of Privacy Practices and decline to accept.**

_____ _____

(Sign) Patient Name Date (Print) Patient Name Date

_____ _____

(Sign) Parent/Legal Guardian Date (Print) Parent/Legal Guardian Date

_____ _____

(Sign) Witness Date (Print) Witness Date