AUTHORIZATION FOR TREATMENT/PAYMENT AND RELEASE OF INFORMATION
&
ACKNOWLEDGMENT OF RECEIPT NOTICE OF PRIVACY PRACTICES
&
ACKNOWLEDGMENT OF PHARMACY RELEASE

Patient Name: _____ **Date of Birth:** _____

-I hereby authorize Scenic Bluffs Community Health Centers to provide services as considered necessary and/or appropriate.

-I hereby authorize Scenic Bluffs Community Health Centers to disclose any medical or other health information to my insurance carrier or its agent **should it be needed for payment of claims**.

-I UNDERSTAND THAT IF I RECEIVE TREATMENT FOR **MENTAL ILLNESS, HIV, DEVELOPMENTAL DISABILITIES, DRUG AND ALCOHOL ABUSE, THESE RECORDS ARE INCLUDED**.

-I assign payment directly to Scenic Bluffs Community Health Centers for benefits otherwise payable to the insured.

-I understand that I am financially responsible for the services rendered, or materials and equipment used to the extent that insurance benefits do not pay my bill. This is a family purpose obligation and our marital assets as well as my individual assets shall be available to satisfy this obligation.

-A photocopy/facsimile of this authorization shall be as valid as the original and may be cancelled at any time.

-I acknowledge that I have received a copy of Scenic Bluffs Community Health Centers' Notice of Privacy Practices.

-I authorize Scenic Bluffs Health Center and it's providers to view my external prescription history via Surescripts and/or AllScripts prescription service. I understand that prescription history from multiple other unaffiliated providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years. My signature certifies that I read and understand the scope of my consent and that I authorize access.

_____ _____
Signature **Date**

_____
Printed Name of Person Signing (If Not Patient) **Relationship (check one):** ❑ Parent ❑ Legal Guardian