AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS FOR PATIENTS

PATIENT NAME:_________________________________ DOB:_____________

I hereby authorize and direct my insurance benefits to be paid directly to my personal physician or Modern Gynecology.

I also authorize Modern Gynecology to release any information necessary to process this claim. I understand that information will be released to:

Billing department of the physician and/or practice
Insurance carrier to process claim

I understand that my information, under certain circumstances may be released for one of the following reasons:

- Other Healthcare professionals in order to coordinate my care or treatment
- Insurance adjuster - if my claim is a work or motor vehicle injury
- Employer - if my claim is related to a work injury
- Attorney - if my claim is in a litigation process
- Health insurance carrier, for chart audit reason, and for claim payment

I understand that Modern Gynecology and/or their staff and billing office will not release any information to myself or family members over the phone without verification of my identity in order to comply with privacy regulations. I also understand that Modern Gynecology and/or their staff and billing office will maintain the utmost respect for privacy. However, I also understand that there are physical constraints such as noise and the ability for others to overhear information, and other errors that may occur, which may cause inadvertent dissemination of information, as well as the potential for confidential information to be disclosed after it has been provided to outside sources such as your insurance carrier from the clinical or billing office.

This office is not responsible for any disclosure of your confidential medical information once we provide this information, AT YOUR request, to your insurer, employer, family member or otherwise.

With this full understanding, I indemnify and hold harmless this practice for any disclosure, which is out of my physicians, their staff and/ or their billing office control.

By my signature, I state that I have read, understood, and agree to this Authorization and Release.

___________________________________ ______________________

Patient or Guardian Signature Date

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