RELEASE OF INFORMATION AGREEMENT

1. **AUTHORIZATION FOR CARE**

The undersigned voluntarily agrees to treatment and services that his/her medical provider deems necessary,

2. **RELEASE OF INFORMATION FOR BILLING SERVICES AND REVIEW**

Passamaquoddy Health Center may disclose all or any reasonable part of the patient's record to include information pertaining to medical history, mental or physical condition, alcohol/drug abuse and psychiatric diagnosis to any person or entity for the purpose of billing all or part of PHC's charges to include but not limited to any person, insurance companies, employer, utilization review, evaluation, financial audit and for any other purpose reasonably related to these activities. The undersigned understands that this authorization will remain in a long term period, unless revoked in writing prior to that date.

3. **ASSIGNMENT OF INSURANCE BENEFITS**

I hereby authorize payment directly to the Passamaquoddy Health Center. Authorization is not limited to private health insurance but may include other sources such as Medicare/Medicaid liability claims and/or reimbursable insurance for any services I receive. I also authorize that the Patient Service Coordinator has authorization to receive and request any information pertaining to my health insurance.

4. **MEDICAID/MAINECARE**

State regulations require you to present a current identification card every time you receive service. Every patient is required to submit an application for Medicaid if referred by the Patient Service Coordinator, Contract Health Clerk, or other provider. Failure to comply with the Medicaid application process may result in denial for Contract Health Services. By signing this agreement, authorization is given to the PHC Patient Service Coordinator is able to speak to a case worker at D.H.H.S. on your behalf.

5. **MEDICARE PART B AND D**

Part B covers professional services, durable medical equipment, laboratory, and preventative services. Part D covers prescriptions ONLY. By signing this agreement, authorization is given to the PHC Patient Service Coordinator to be able to speak with D.H.H.S. or the Social Security Administration on your behalf.

6. **PRIVATE INSURANCE**

It is the patient's responsibility to present ALL insurance card(s) to any health center, doctor's office, pharmacy, or hospital at time of service.

7. **AGREEMENT**

By signing this form I understand the contents of the Service Agreement and have received a copy. I understand the interpretation of this agreement which was explained to me. This release will expire one (1) year from the date of my signature.

____ ____

Client, Guardian/Guarantor Signature Date Signature and Title of PHC Employee Date

CHART #_________ NAME: (Last, First)____ DOB: _______________

401 Peter Dana Point Road, P.O. Box 97, Indian Township, ME 04668-0097
Phone 207.796.2321 | Fax 207.796.2195

Acknowledgement of Receipt of PHC Notice of Privacy Practices

I hereby acknowledge receipt of the Indian Health Service (PHC) Notice of Privacy Practices at the Passamaquoddy Health Center located at 401 Peter Dana Point Rd., Indian Township, ME 04668.

CHART #_________ NAME: (Last, First)___________________________________ DOB: _______________

____ _______________________

Signature of Patient Date

____ _______________________

Signature of Patient Representative Date
(State relationship to patient)
Or Witness (if signature is by thumb print or mark)

____ _______________________

Signature and Title of PHC Employee Date

For Patients Unable to Acknowledge Receipt

I hereby certify that the patient was unable to acknowledge receipt of the PHC Notice of Practices because:

____
(state reason)

____ _______________________

Signature of and Title of PHC Employee Date

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