INSURANCE AUTHORIZATION

I authorize payment of insurance benefits directly to my provider. I understand that I am personally responsible for charges not covered by my insurance including deductibles and co-payments. I also understand that fee estimates given to me by my provider are not a guarantee of payment by my insurance and are subject to variation based on my individual insurance carrier and my insurance plan.

AUTHORIZATION TO RELEASE INFORMATION:

I authorize the release of any medical or other information necessary to: another requesting physician (for continuation of care or referrals), an insurance carrier for processing of a claim for benefits, or to my requesting pharmacy/medical supply company for processing of a medication/medical device.

PRIVACY NOTICE

I have been advised of this office's privacy notice and can obtain a copy upon request. The privacy notice is also available on our website: www.singletrackhealth.com.

PATIENT CENTERED MEDICAL HOME

I understand that I may be a part of the Patient Centered Medical Home. The **Patient-Centered Medical Home** (**PCMH**) is a care delivery model whereby **patient** treatment is coordinated through a patient's primary care physician to ensure the patient receives the necessary care when and where they need it, in a manner the patient is able to understand.

ELECTION TO ELECTRONICALLY TRANSMIT MEDICAL INFORMATION

I authorize Singletrack Health, P.C. to furnish a copy of the medical record of my treatment, my discharge summary, and/or a summary of care record to my specialty care physician, and/or any health care provider or facility identified in my plan of care to facilitate my treatment and continuity of care. I understand that information disclosed under this paragraph may include, among other things, confidential HIV-related information and other information relating to sexually transmitted or communicable diseases, information relating to drug or alcohol abuse or drug or alcohol dependence, mental or behavioral health information (excluding psychotherapy notes), genetic testing information, and/or abortion-related information. The summary of care record consists of information from my medical record, including information concerning procedures and lab tests, my care plan, a list of my current and historical problems, and my current medication list. I understand that I may revoke this authorization at any time by placing a written request to my healthcare provider. I understand that a healthcare organization is unable to take back information that has already been released under this authorization once transferred. I further understand that if I participate in the use of the patient web portal, I am responsible for the safeguarding of the computer I am accessing my personal information with and/or any information printed from the web portal by myself.

OPTIONAL AUTHORIZATION TO RELEASE INFORMATION

I, _____, give Singletrack Health, P.C., permission to speak with the following people regarding my medical and/or financial information. This authorization is valid until such time as I provide Singletrack Health, P.C. with a written revocation of it.

_____ _____Please Circle: Financial Medical
Name and Phone Number Relationship to Patient

_____ _____Please Circle: Financial Medical
Name and Phone Number Relationship to Patient

ADVANCED DIRECTIVE ON FILE (Circle One): Yes No Offered Advanced Directive: Yes No

I HAVE READ THIS CONSENT AND I AM FULLY AWARE OF AND AGREE TO THE CONTENTS.

SIGNATURE _____ DATE: _____
Patient Name (Printed): _____ Patient Date of Birth: _____