Authorization to Release Information and Assignment of Benefits

I authorize the release of my medical information necessary to process this claim. I permit a copy of the authorization to be used in the place of the original. I hereby authorize Elizabeth Avaricio MD, PLLC to apply for benefits for the covered services rendered by his or by her order. I request that payment from my insurance company be made directly to Elizabeth Avaricio MD, PLLC. I permit a copy of authorization to use in place of the original. This authorization may be revoked by either me or my insurance company at any time.

Patient Consent for use and Disclosure of Protected Health Information

I have read a copy of Elizabeth Avaricio MD, PLLC Notice of Privacy Practices. With my consent, Elizabeth Avaricio MD, PLLC may use and disclose protected information (PHI) about me to carry out treatment, payment, and healthcare operations. With My Consent, Elizabeth Avaricio MD, PLLC may call my home or other designated locations and leave messages on voicemail or in person in reference to any items that assist the practice to carrying out such as appointment reminders, insurance items and call pertaining to clinical care, including laboratory results among others. With My Consent, Elizabeth Avaricio MD, PLLC may mail to my home or other designated locations any items that assist the practice in carrying out such as appointment cards and patient statements. By signing this form, I am consenting Elizabeth Avaricio MD, PLLC use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures reliance upon my prior consent. If I do not sign this Consent, Elizabeth Avaricio MD, PLLC may decline to provider treatment to me.

Date: ______________________________

Signature: ______________________________

Print Name: ______________________ ***Relationship:*** __________