Signature on File Form for Authorization of Access to Medical Records, Assignments of Benefits and authorization to contact patient regarding confirmation of appointments and test results

I, _____ (print your name) provide this signature as authorization for payment of all my medical services to High Ridge Family Practice, LLC (for any of the Family Practice associated providers: Alan T. Falkoff, M.D. and/or David M. Berkun, M.D., and/or any other authorized A.P.R.N. or P.A. also called "the providers" herein). I understand that any services not covered by my insurance will become solely my (the patient's) responsibility. I authorize the providers as well as the office staff for High Ridge Family Practice, LLC to permit the release of medical or other information necessary to process insurance claims. I also request payment of government benefits directly to High Ridge Family Practice, LLC (as noted above for any/or all of the providers), at the above address for all medical services rendered. I provide this signature as authorization for payment of all my medical services to High Ridge Family Practice, LLC for services rendered by the providers and the office staff of High Ridge Family Practice, LLC at the following address:

High Ridge Family Practice, LLC
30 Buxton Farms Road, Suite 210
Stamford, CT 06905

Additionally, in accordance with new federal and state government regulations under HIPPA (began 10/2002) I authorize the providers as well as the office staff for High Ridge Family Practice, LLC to contact me to confirm appointments and advise me of the results of any of my medical tests or procedures. They **[ ] may or [ ] may not** leave a message with an answering machine of persons taking messages at the phone number(s) I provide on my registration form.

I provide this signature as acknowledgement that I have been presented with and have read and understood the Office Policies & Procedures information provided to me by High Ridge Family Practice, LLC. This includes but is not limited to the Patient Registration Form (2 pages), the Office Policies regarding Non-Covered Services, the Patient Responsibility List and the High Ridge Family Practice Responsibility to Patient's List.

_____ _____

Signature of Patient or Legal Representative

Date

This form is valid until indicated by the above signee in writing of other arrangements

Signature on File Form for Prior Authorization of Release of Medical Records & Discussion of Care

I, _____ (print your name) authorize High Ridge Family Practice, LLC (the providers at HRFP either/or any of the providers: Drs. Falkoff / Berkun , and/or any other authorized A.P.R.N. or P.A.) as well as the office staff for High Ridge Family Practice, LLC to [ ] discuss my care and/or [ ] release my medical records including but not limited to progress notes, consults, hospital reports, immunizations, communications and the results of any of my medical tests or procedures to the below individual(s):

_____

_____

_____

_____

_____

_____ _____

Signature of Patient or Legal Representative

Date

This form is valid for a period of one (1) year from the date indicated by the above signee