Signature on File Form, Authorization of Access to Medical Records & 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 physicians: Alan T. Falkoff, M.D. and/or Joshua B. Herbert, M.D. and/or David M. Berkun, M.D. and/or Saloni Anand M.D. and/or Elena E. Gazzola, M.D.) at the following address:

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

I understand that any services not covered by my insurance will
become solely my (the patient's) responsibility.

________________________________ ______________
Signature of Patient or Date
Legal Representative

Additionally, in accordance with new federal and state government
regulations under HIPPA (began 10/2002)

I, ______________________________ (print your name) authorize
High Ridge Family Practice, LLC (the physicians at HRFP either/or
any of the physicians Dr. Falkoff / Herbert / Berkun / Anand /
Gazzola as well as the office staff for High Ridge Family Practice, LLC to contact me to confirm appointments (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).

__________________________________ ________________

Signature of Patient or Legal Representative **Date**

(continued on back of page)

Signature on File Form, Authorization of Access to Medical Records & Authorization to contact patient regarding confirmation of appointments and test results (page 2 of 2)

I, ________________________________ (print your name) authorize High Ridge Family Practice, LLC (the physicians at HRFP either/or any of the physicians Dr. Falkoff / Herbert / Berkun / Anand /Gazzola as well as the office staff for High Ridge Family Practice, LLC to contact me to 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).

__________________________________ ________________

Signature of Patient or Legal Representative **Date**

I, ________________________________ (print your name) authorize High Ridge Family Practice, LLC to permit the release of medical or other information necessary to process this claim.
I also request payment of government benefits directly to High Ridge Family Practice, LLC (as noted above for any/or all of the physicians), at the above address for all medical services rendered.

__________________________________ ________________

Signature of Patient or Legal Representative **Date**

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

of other arrangements