
ORTHOPAEDIC INSTITUTE

# Authorization form

## Growing Bones Pediatric & Neuromuscular Orthopaedic Institute

### Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize **Growing Bones Pediatric & Neuromuscular Orthopaedic Institute** to use and/or disclose certain protected health information (PHI) about me to _____ ☐ None

This authorization permits **Growing Bones Pediatric & Neuromuscular Orthopaedic Institute** to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

The information will be used or disclosed for the following purpose:

(If disclosure is requested by the patient, purpose may be listed as "at the request of the individual.")

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire 1 year following the date of authorization

The Practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from **Growing Bones Pediatric & Neuromuscular Orthopaedic Institute**. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at:

**Growing Bones Pediatric & Neuromuscular Orthopaedic Institute**

**1057 South Bradford Street**

**Dover, DE 19707**

*Family and Friends*

I authorize the practice to discuss appointment dates, times, location, medical history, diagnosis, treatment, prognosis, financial insurance, and billing information with those listed below. I understand that my or my child's healthcare provider will use his judgement in sharing this information in order to foster continuity of care. The release of copies of medical records will require a signed HIPPA compliant authorization. The permission will be considered on-going until I indicate otherwise in writing.

PHI may be released to the following individuals:

| Name | Relationship To Patient |
|---|---|
| 1. _____ | _____ |
| 2. _____ | _____ |
| 3. _____ | _____ |
| 4. _____ | _____ |

| | YES | NO |
|---|---|---|
| The practice staff have my permission to share my or my child's personal | ☐ | ☐ |
| Health information with family members or others who are in the room With me/us during appointment | ☐ | ☐ |

The practice staff have my permission not leave messages concerning treatment

Signed by: _____ _____

Signature of Patient or Legal Guardian — Relationship to Patient

_____ _____

Print Patient's Name — Date

_____

Print Name of Patient or Legal Guardian, if applicable

Patient/guardian must be provided with a signed copy of this authorization form.

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# Assignment of Benefits

I, understand that services rendered to me by Growing Bones Pediatric & Neuromuscular Orthopaedic Institute are my financial responsibility and that the provider will bill my insurance company (ies) as a courtesy. I authorize my insurance company to pay my benefits directly to Growing Bones Pediatric & Neuromuscular Orthopaedic Institute and I understand that I will be fully responsible for any outstanding balance on my account. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

This payment will not exceed my indebtedness to the above-mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. I have been given the opportunity to pay my estimated deductible and coinsurance at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim. I authorize the provider to release any information necessary to adjudicate the claim, and understand that there may be associated costs for providing information beyond what is necessary for the adjudication of a clean claim.

Any violations of this agreement will, at provider's election, terminate patient charge privileges with provider and bring any balance owed by patient to provider immediately due and payable. A photocopy of this Assignment shall be considered as effective and valid as the original. I authorize the provider to initiate a complaint or file appeal to the insurance commissioner or any payer authority for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

Signature of policyholder Patient or Guardian

Date