Anke Ott Young, M.D.

AUTHORIZATIONS

Patient Name: ____ **Patient ID:** _________________________

☐ **Initial** **Privacy Statement & Acknowledgement of receipt**

A notice of HIPAA Privacy Policies are available and posted in our office detailing how my health information may be used and disclosed as permitted under federal and state law**.**

☐ **Initial** **Authorization for Access/Release of information**

I hereby authorize the use and/or disclosure of my individually identifiable health information. I understand that this authorization is voluntary. I also understand that my patient information may be subject to re-disclosure by the authorized recipients of the information and that my information may no longer be protected by federal privacy regulations.

☐ **Initial** **Insurance Carrier**

I hereby authorize Anke Ott Young, M.D. and personnel to release any information necessary, acquired in the course of my treatment to any insurance company with whom the patient is under contract to process claims.

I hereby authorize my insurance company to pay Anke Ott Young, M.D. directly for medical services rendered. I understand that I will be responsible for non-covered charges, balances after insurance company benefits, deductible, co-insurance and co-payments. If my insurance processes a claim for services rendered by Anke Ott Young, M.D. and pays me directly, I will submit the amount received directly from my insurance company for all service dates to Anke Ott-Young, M.D. or personnel.

Family Member

I hereby authorize Anke Ott Young, M.D. and personnel to discuss my protected health information with my family member(s).

Name: ____ **Relationship:** ______________________________

Name: ____ **Relationship:** ______________________________

Name: ____ **Relationship:** ______________________________

Description of any information to use or disclose (including dates) if applicable.

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I authorize your office to leave messages on my voice mail/machine. ☐ **Yes** ☐ **No**

Signature of patient/parent/legal guardian/authorized person: ____

Date: __________________