Doylestown Health Physicians

Patient's Name_____ Date of Birth_____

Authorization to Disclose Health Information

I hereby authorize **Doylestown Health ~ General Surgery, VIA Affiliates** to release my PHI (protected health information) to:

Myself only_____

My spouse/significant other _____
Name of person

My Children_____ _____
Name of person

_____
Name of person

_____
Name of person

Other_____ _____
Relationship to Patient Names of person/organization

_____I give my permission to LEAVE MESSAGES ON VOICE MAIL regarding: test results, answers to questions, appointment information, etc.

Doylestown Health ~ General Surgery
VIA Affiliates

1. Acknowledgement of Receipt: I acknowledge I have been provided the VIA Affiliates' Notice of Privacy Practices on this day.

2. Assignment of Benefits: I hereby assign to VIA Affiliates all benefits payable to me for my care and/or treatment.

3. Financial Agreement: I agree to be responsible for charges not covered by insurance. In consideration of the service to be rendered, I acknowledge the obligation to pay VIA Affiliates in accordance with its regular rates and terms. I acknowledge that I am responsible for any copay and coinsurance at the time of service. I understand that VIA Affiliates reserves the right to charge a fee for any checks returned for non-payment.

_____ _____ _____ _____
Signature of Patient/Guarantor Time Date Relationship to Patient

_____
If Patient is unable to sign, please state reason and initial

_____ _____ _____
Signature of Witness Time Date

I hereby acknowledge that I have read this form and have had the opportunity to ask questions and had them answered.

_____
Initials