AUTHORIZATION and CONSENT AGREEMENT

Thank you for reviewing our Financial and Office Policies and Notice of Privacy Practices. Please sign in the spaces provided below to acknowledge receipt of this information, and to enter your authorized contacts.

ASSIGNMENT of BENEFITS

I authorize direct payment to be made to the physicians of Village Health Partners (VHP) or Village Pediatrics (VP) for any and all medical or surgical services rendered. I also authorize the release of any medical records for the purpose of my healthcare services.

FINANCIAL AND OFFICE POLICIES

I have read and understand the Financial and Office Policies of VHP and agree to abide by its guidelines.

HIPAA

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I can request a copy of this notice at any time. I have the right to review the notice prior to signing this consent.

I have had the opportunity to receive and review the Notice of Privacy Practices of Village Health Partners and Village Pediatrics.

APPROVED HIPAA CONTACTS

Disclosure of Protected Health Information

Keeping information private is important to us and by default we will only disclose information related to the patient's **Billing Account** and **Medical Conditions** to the **patient** or **legal guardian**. Please note, in order to share protected health information with your spouse they must be listed as an approved contact.
The following names are people I would like to be involved in or have access to my protected health information on a routine basis. I give permission for VHP to share my protected health information with:

Contact Name	**DOB**	**Relationship to Patient**
Contact Name	**DOB**	**Relationship to Patient**

CONSENT and AGREEMENT

I have carefully reviewed this document and agree to fully comply with guidelines defined herein related to the Assignment of Benefits, Financial Policy, HIPAA Policy and Approved HIPAA contacts. The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for health information from persons not listed on this form will require my specific authorization prior to the disclosure of any personal health information.

Patient's Name (Please Print)	**Patient's DOB**
Signature of Patient, Parent, or Legal Guardian	**Date**