Patient Name: _____ MRN: _____ DOB: _____

AUTHORIZATION TO RELEASE INFORMATION. I hereby authorize Columbia St. Mary's Hospitals and Clinics to release to any and all public and private health care insurers information from my medical record for legitimate purposes of payment of my bill. I understand that the information may include diagnosis and treatment for physical and/or mental illness including alcohol and drug abuse, developmental disabilities, and/or AIDS/HIV related disorders. This authorization may be revoked in writing at any time except to the extent that releases have already been made, and will expire without express revocation whenever legal or contractual obligations or the evaluation or treatment at the Columbia St. Mary's Hospitals and Clinics have been completed. I understand that I may inspect any medical records at my own expense.

ASSIGNMENT OF BENEFITS. I hereby authorize, request and assign payment directly to the Columbia St. Mary's Hospitals and Clinics by all insurance carriers and Social Security administrators with whom I have coverage or for who benefits are, or may become, payable to me, including settlements of judgments arising from the incident for which I am receiving treatment. I agree to pay the Hospital, Clinic and physicians all charges not paid by my insurance plan.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE / PATIENT RIGHTS AND RESPONSIBILITIES

- ☐ I acknowledge that I have been offered a copy of Columbia St. Mary's Notice of Privacy Practices.
- ☐ I acknowledge that I have been offered the Patient Rights and Responsibilities brochure.
- ☐ I understand that the Notice of Privacy provides an explanation of the ways in which my health information may be used or disclosed by Columbia St. Mary's and of my rights with respect to my health information.

Date Privacy Notice Previously Received _____

Please sign on white copy. Thank you.

The undersigned has read and understands the above.

Date _____

_____
(Signature of Patient or Patient's Legal Representative - if patient is unable to sign)

_____
(Relation to Patient)

_____
(Witness / Staff Signature if patient unable or unwilling to sign)

FOR OFFICE USE ONLY

☐ Patient was unable or unwilling to complete this form or portions of this form.
Explain. _____