ALSA
Advanced Laparoscopic Surgery Associates Medical Group, Inc.

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

1. I authorize the use or disclosure of the above named individual's health information as described below:
2. The following individual or organization is authorized to make the disclosure:

Advanced Laparoscopic Surgical Association Medical Group, Inc.
205 E River Park Circle, Suite 460, Fresno CA 93720

3. The type and amount of information to be used or disclosed is as follows:
(include dates where appropriate)

☐ Entire Record
☐ Problem List
☐ Medication List
☐ List of Allergies
☐ Laboratory Results
☐ X-Ray and Imaging Reports
☐ Consultation Reports
☐ Other: _____

☐ Psychological Evaluation
☐ Most Recent History and Physical
☐ Most Recent Discharge Summary

From (date) _____ to (date) _____
From (date) _____ to (date) _____
From (doctor's name) _____

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. **This information may only be released if this box is checked and initialed.** ☐_____ Psych Evaluation ****PLEASE INITIAL ****

5. This information may be disclosed to and used by your insurance in order to obtain authorization for surgery.

6. I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the medical records department. I understand the revocation will not apply to information that has already been released in response to this policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition _____. If I do not specify an expiration date, event or condition, this authorization will NOT expire.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for any unauthorized re-disclosure and the information may not be protected by Federal confidentiality rules. If I have questions about the disclosure of my health information, I can contact the Office Manager.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If Signed by Legal Representative, Relationship to Patient Witness

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Medical Group, Inc.

This is to notify ALSA that I, _____date of birth_____
give permission to discuss my medical history, treatment, plans, test results, scheduling and insurance information with the following persons:

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

This authorization is only voided by a written request signed by the patient.

Signed: _____ Date: _____

ASSISTANT SURGEON FEE NOTICE

The assistant surgeon's role in surgery is a vital part of the surgical team. Your operation could not be performed without the help of the assistant surgeon. Over the past few years, more and more insurance companies are denying payment to the assistant surgeon for their role in your surgery.

We will be billing your insurance company for the charges of the assistant surgeon. However, should your insurance company deny the payment of the assistant surgeon fee, you would be responsible for the payment of that charge. ALSA will discount the fee that you will owe for the payment of the assistant surgeon fee to $500.00. Should your insurance pay the assistant surgeon fee, you will only be responsible for the amount that your insurance states as your responsibility.

Please sign this notice below to indicate your understanding of the payment for the assistant surgeon fee.

Signed: _____ Date: _____

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RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize the release of information regarding my medical treatment care and charges as may be required to complete all claims of benefit.

I hereby authorize my insurance benefits to be paid directly to Advanced Laparoscopic Surgery Associates Medical Group, Inc. I understand I am financially responsible for all charges not covered by my insurance company.

Co-payments and deductibles are payable at the time service is rendered.

For those patients belonging to prepaid HMO or PPO groups, it is your responsibility to inform this office regarding limitations on referrals. Advanced Laparoscopic Surgery Associates Medical Group, Inc. will not be responsible for services incurred for any referral not received.

Signed: _____ Date: _____

INFORMED CONSENT

I understand that I will be financially responsible for any non-covered medical services performed by Advanced Laparoscopic Surgery Associates Medical Group, Inc. that was denied by my insurance company.

Signed: _____ Date: _____

MEDICARE AUTHORIZATION STATEMENT AND CLAIMS SUBMISSION

I request that payment of authorized Medicare benefits be made on my behalf to Advanced Laparoscopic Surgery Associates Medical Group, Inc. for any services furnished by the Physician/ Supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

Signed: _____ Date: _____

RELEASE OF MEDICAL RECORD INFORMATION

Patient Name: _____ Date of Birth: _____

Information to be used for continued care to the other MD

Advanced Laparoscopic Surgery Associates Medical Group, Inc.
205 E River Park Circle, Suite 460
Fresno CA 93720
(559) 261-4500
(559) 261-4501 (fax)

Signed: _____ Date: _____