Shiloh Clinic P.L.C.

Shiloh Clinic, PLC Financial and Health Information Practices

Financial Practice:

I authorize my insurance benefits be paid directly to Shiloh Clinic, PLC. I understand that I am financially responsible for any unpaid balances such as: co-pays, deductibles, and any non covered balances. I also, authorize Shiloh Clinic, PLC, or the insurance company to release any information required to process my claims. A photocopy of the assignment is to be considered as valid as an original.

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Patient/Parent/Guardian Signature Date

Health Information Practices:

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

I authorize Shiloh Clinic, PLC to use and disclose the protected health information described below:
I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and the treatment of alcohol or drug abuse.)
This medical information may be used for medical treatment or consultations or other purposes as I direct.
I understand I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective in the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I have read and understand the above practices of Shiloh Clinic, PLC

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Patient /Parent /Guardian Signature Date

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Print Name Date of Birth

May release my information to:

_____

Family Member or Friend Relationship Phone

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Family Member or Friend Relationship Phone