Harrison Family Practice Clinic
Washington Regional

I authorize release of any medical information necessary to process my claim to all my insurance companies. I authorize direct payment of medical benefits to the provider. I permit a copy of this authorization to be used in the place of the original. I consent for my photo to be taken. I understand that I am responsible for any amount not covered by insurance. I permit the faxing and electronic transmission of medical information to other health care providers, attorneys or insurance companies involved in my care. I give my permission for messages to be left on my answering machine or sent by email. I, the undersigned, authorize and consent to the rendering of medical care, including diagnostic procedures and medical treatment by authorized members of Washington Regional Medical System or their designees, as may in their professional judgment be necessary for the above named patient. I acknowledge that no guarantees have been made as to the effect of such examinations or treatment. I have received a copy of the Notice of Privacy Practices of the clinic. I permit this facility to obtain my medication history electronically.

_____ Date: _____
Signature (Patient or Parent/Guardian if minor)

PRIMARY INSURANCE

Patient's Relationship to the Insured: □ Self □ Spouse □ Child □ Other: _____

Name of Insurance Company: _____

Insurance Company Address: _____

ID# _____ Group # _____

Insurance Company Phone # _____

Insured Name: _____

Insured Address: _____

Insured Date of Birth: _____ Insured Social Sec # _____

SECONDARY INSURANCE

Patient's Relationship to the Insured: □ Self □ Spouse □ Child □ Other: _____

Name of Insurance Company: _____

Insurance Company Address: _____

ID# _____ Group # _____

Insurance Company Phone # _____

Insured Name: _____

Insured Address: _____

Insured Date of Birth: _____ Insured Social Sec # _____