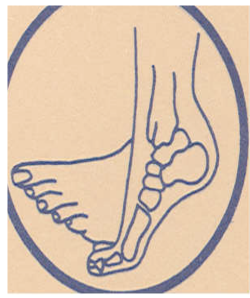

Barth A Wolf DPM & Daniel F Reznick DPM

Podiatry Offices

Board Certified Foot and Ankle Care

Chelsea Podiatry
1200 South Main Street
Chelsea MI 48118
734 475-1200
734 475-9210 (fax)

Authorization for Record release and Payment

1. Authorization for Release of patient Records

   I, ______________________________, Authorize Reznick, Wolf and Associates, P.C. to release information contained in my patient records to the referring physician identified in my Patient Information form and/or to any other physician or health care professional/entity to whom I may be referred to by Reznick, Wolf and Associates, P.C.

2. I was given the opportunity to read the office **Notice of Privacy Practices.** I understand my rights to access my medical records, disclosure of my personal information and that I have a right to request an amendment to my health information. I realize I am entitled a copy of their **Notice of Privacy Practices** if I so choose.

3. Authorization for Payment

   I Authorize the release of any protected health information (PHI) necessary to process claims for payment. I hereby authorize payment of insurance benefits, including Medicare benefits, to be made directly to Reznick, Wolf and Associates, P.C. I understand that I am financially responsible to Reznick, Wolf and Associates, P.C. for services not covered or payable by my insurance carrier.

4. Lifetime Medicare Authorization

   I request that payment of authorized Medicare benefits be made either to me or on my behalf to Reznick, Wolf and Associates, P.C. or its agent, for any services furnished to me by that supplier. I authorize any holder of hospital or medical information about me to release to the Social Security Administration Centers for Medicare, or its intermediaries or carriers any information of documentation needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original. I understand Reznick, Wolf and Associates, P.C. may use this authorization for all services in the future until such time as I revoke this authorization in writing. (Section 1128B of the Social Security Act and 31 U.S.C. 381-3812 provides penalties for withholding this information).

____________________________ ____________________
Patient Name Date

____________________________ ____________________ ___________
Parent or Guardian Relationship to patient Date