Lakeland Regional Health®

LRH PHYSICIANS GROUP
RELEASE/AUTHORIZATION FORM

PATIENT	INSURANCE
NAME	COMPANY NAME
ADDRESS	GROUP Group #
CITY STATE ZIP	PATIENT PHONE
EMPLOYER	EMPLOYER PHONE
DOB	SUBSCRIBER DOB
PHYSICIAN	POLICY #

The undersigned being the patient and/or guaranteeing party in connection with this account, HEREBY AGREES TO THE FOLLOWING:

1. AUTHORIZATION TO DISCLOSE AND RECEIVE INFORMATION: The undersigned hereby authorizes Lakeland Regional Health Systems, Inc. d/b/a Lakeland Regional Health Physicians Group (LRHPG) to release and obtain information from insurance carriers listed in the patient's record or any insurance carrier represented as contractually responsible for payment in whole or in part of the patient's health care bill and such diagnostic and therapeutic information and records (including any treatment or testing for mental illness, alcohol abuse, drug abuse, or HIV/AIDS) as may be necessary to determine benefits entitlement and to process payment claims for health care provided to the above-named patient. This authorization shall be valid only for the period of time necessary to actually process payment claims pertaining to the patient, but in any case shall cease to be valid 18 months from this date.

I authorize LRHPG, its business associates, any healthcare providers who provide care to me and their business associates (a) to contact me by telephone (including wireless or cellular phone) using any telephone number I have provided or is associated with my record, which could result in a charge to me, and (b) that such contact may be through the use of automated dialing technology and/or pre-recorded messages. I also authorize release of medical and financial information for ongoing care, payment/billing purposes, quality assurance and other health care operations to my personal physician or to any healthcare providers, agencies and professionals who attend to me during my care or cooperate with LRHPG in the treatment process. I further authorize the release of diagnostic and therapeutic information and records (including any treatment or testing for mental illness, alcohol abuse, drug abuse, or HIV/AIDS) to Lakeland Regional Medical Center Foundation, Inc. to be used only for its educational, scientific, and charitable purposes in support of LRHPG. I understand that the above authorizations are subject to revocation except to the extent that action has been taken in reliance thereon.

I consent to receiving text messages from LRHPG about my medical care to the phone number provided above. I acknowledge that I can unsubscribe at any time by replying "STOP" to a text message received from LRHPG, and that such messages could result in a charge to me.

2. IRREVOCABLE ASSIGNMENT FOR INSURANCE BENEFITS AND APPOINTMENT OF AUTHORIZED REPRESENTATIVE. I assign to LRHPG all rights to any insurance and legal causes of action I may have which may result in recovery of insurance benefits, of any nature, whether third party or otherwise, and I appoint LRHPG as an Authorized Representative for my Employee Benefits or ERISA qualified plan. This Assignment includes any and all Personal Injury Protection coverage (PIP), health, disability, liability coverage, self-insurance, employment-based benefits, third party insurance coverage or any other insurance coverage. I authorize and direct any insurance carrier, including third-party carriers or benefits administrator, responsible for payment in whole or in part of the patient's (my) health care bill, to accept claims from, and to pay directly to LRHPG all the insurance or benefits or coverage otherwise payable to, or for, (me) the patient. I agree to forward to LRHPG all insurance, benefits, and other third-party payments that I receive for services rendered to me immediately upon receipt. This assignment and appointment includes authorization for receipt of motor vehicle accident reports; and any and all legal remedies to include applications, determination of eligibility, claims and appeals for benefits to enforce payment of the insurance or benefits proceeds. LRHPG is under no obligation to bring any action against any party. LRHPG may transfer this assignment at its discretion. Any waiver of this assignment, or appointment, must be in writing from an authorized LRHPG representative.

3. MEDICAID AUTHORIZATION. If Medicaid applies, I certify that I am a recipient of the Medicaid program, Title XIX, and request that payment of authorized benefits be made on my behalf and authorize LRHPG and my insurance carrier to make available to the Florida Department of Children and Families, and to give to or obtain from any health care facility or physician, any requested information concerning medical, insurance and financial records relating to my treatment. I hereby certify all insurance shall be assigned to LRHPG.

4. LIFETIME AUTHORIZATION FOR MEDICARE ASSIGNMENT AND AUTHORIZATION TO RELEASE INFORMATION: If Medicare applies, I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to or obtain from the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I understand that this is a lifetime authorization. I request that payment of authorized benefits be made in my behalf. I assign the benefits payable for services rendered by LRHPG, and its physicians and providers; including payment for unpaid charges for certain physician consultations furnished by specialists, or by physicians for whom LRHPG is authorized to bill. I understand that I am responsible for any health insurance deductibles and coinsurance.

5. STATEMENT OF FINANCIAL RESPONSIBILITY: In consideration of treatment and services provided by LRHPG, the undersigned unconditionally guarantees payment of the account balance at discharge of the patient. LRHPG processes verified, assigned insurance claims as a courtesy, but LRHPG's effort to collect insurance proceeds does not affect the patient/undersigned's responsibility for any account balance. All uninsured balances remain payable at discharge. If it is necessary to refer this account for collection to enforce these obligations, the patient and/or undersigned agrees to pay all collection expenses, including LRHPG's reasonable attorney's fees. The proper venue for any legal action shall be in Polk County, Florida.

6. AUTHORIZATION FOR MEDICAL AND/OR SURGICAL TREATMENT: I hereby authorize LRHPG and physician or physicians in charge of the care of me, or the above-named patient, to administer any treatment, to administer such anesthetics and medications, to perform such operations (including blood transfusions), to perform such laboratory procedures and tests (including but not limited to blood tests for HIV/AIDS), and to dispose of any tissues, body parts, or organs removed as he, she, or they deem necessary or advisable in the diagnosis and treatment of this patient. I further direct LRHPG, its agents, and employees to follow the instructions and directions of the physician or physicians in charge of the care of the above-named patient. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatments or examinations in LRHPG.

7. NOTICE TO PATIENTS REFERRED BY OTHER PRACTITIONERS: In connection with your initial examination or consultation, Florida law gives you the right to decide to see a physician or any other licensed practitioner supervised by the physician. LRHPG utilizes trained and licensed physician assistants (PAs) advanced practice registered nurses (APRNs), and certified nurse midwives (CNMs) to assist in the care of our patients. Our PAs, APRNs, and CNMs work closely with our physicians, and your initial examination or consultation by a PA, APRN, or CNM (if applicable) is reviewed and approved by one of our physicians. Throughout the course of your treatment, it is likely that you will be seen by one of our PAs, APRNs, or CNMs (if applicable) and you might be seen by one of our PAs, APRNs, or CNMs (if applicable) on your initial visit. You have the right to decide whether to see a PA, APRN, CNM (if applicable) or a physician on your initial visit. Therefore, if you decline to be seen and/or treated by a PA, APRN, or CNM on your initial visit, please sign the space below.

Name **Date/Time**

8. RELEASE OF RESPONSIBILITY FOR PERSONAL ARTICLES: No safe is available for outpatient services performed at LRHPG. I agree that LRHPG shall not be liable for any loss of money or damage to my property. I will assume all responsibility for any property.

9. ELECTRONIC HEALTH CARE RECORDS: Personal Health Record for your future health care needs. Lakeland Regional Health Systems, Inc. (LRHS) and LRHPG provide a free, secure, web-based method for patients to access portions of their medical records (Patient Portal). The Patient Portal allows you to take a more active role in managing your health care by safely and securely providing you with access to your Protected Health Information (PHI). In addition, LRHS and LRHPG may participate in and transmit PHI into a global health record system that allows LRHPG, LRHS, affiliated entities, and associates to share PHI for your treatment. LRHS and LRHPG may also participate in various secure health information exchanges that facilitate access to your PHI by other health care providers to provide you with treatment. I acknowledge that my PHI, including records and other information regarding my health history, treatment, hospitalization, clinical laboratory tests, and outpatient care (including any information relating to sensitive conditions including, but not limited to the following: drug, alcohol, or substance abuse; psychological, psychiatric or other mental impairments or developmental disabilities; sickle cell anemia; birth control and family planning; records which may indicate the presence of a communicable disease or noncommunicable disease, including tests and records of HIV/AIDS, sexually transmitted diseases or tuberculosis; and genetic diseases or tests) will be located in the secure Patient Portal and may be transmitted into a global health record system for purposes of my treatment, and only further released or shared with my authorization.

I acknowledge that I have read pages 1 and 2 of this form, including the above numbered sections 1 through 9, and fully understand and agree to their contents.

Patient Printed Name		Guarantor Printed Name	
Patient Signature	Date/Time	Guarantor Signature	Date/Time
Witness #1 Signature	Date/Time	Co-Guarantor Signature	Date/Time
Witness #2 Signature	Date/Time	Guarantor Relationship to Patient	