Cherokee Internal Medicine, P.C.

HIPAA Release

Name:_____ **Date of Birth:**_____

I authorize Cherokee Internal Medicine, P.C. to release protected health information about the above named patient in the following manner and/or to selected person(s).

Email Communication: Cherokee Internal Medicine uses email communication for appointment reminders, telehealth visits, form completion, electronic statements, billing notifications, patient portal account, and may request follow up regarding previous visits with your provider.

Email Address: _____

Text Communication: Cherokee Internal Medicine uses text communication for appointment reminders, telehealth visits, form completion, appointment changes, and may request follow up regarding previous visits with your provider.

Text Phone Number:_____

Voicemail Communication: Cherokee Internal Medicine uses voicemail communication for appointment reminders, appointment changes, lab results, referral details, prescription refills, or other medical recommendations.

Voicemail Phone Number: _____

Other person(s) we may contact: Please list anyone who you allow us to speak with and what can be discussed.

If you do not list anyone in the spaces below we will not be able to speak with anyone other than the patient.

_____	_____	Medical Information Yes ☐ No ☐
Name / Relation	Phone Number:	Financial Information Yes ☐ No ☐
_____	_____	Medical Information Yes ☐ No ☐
Name / Relation	Phone Number:	Financial Information Yes ☐ No ☐
_____	_____	Medical Information Yes ☐ No ☐
Name / Relation	Phone Number:	Financial Information Yes ☐ No ☐

Assignment of Benefits: In consideration of these medical services, I hereby assign, transfer and set over to Cherokee Internal Medicine all my rights, title and interest to medical reimbursement benefits under my insurance policy (s) as indicated below. If my insurance benefits are provided through an ERISA plan (Employment Retirement Income Security Act) I hereby assign, transfer, and set over all my rights, title and interest as beneficiary of the ERISA plan to Cherokee Internal Medicine, with regard to my treatment and care with this practice.

Consent for treatment: I hereby acknowledge and understand that, in presenting myself for treatment and continuing medical care at Cherokee Internal Medicine, PC that I authorize and consent to the administration and performance of all tests and treatments which may be ordered by the provider (and/or designated assistant) and carried out by members of Cherokee Internal Medicine staff and personnel. Minors must be accompanied by a parent/legal guardian for medical care except when the minor is seeking specific services for which they are not required to obtain parental consent, accompaniment or guidance, as clearly expressed by State law.

_____ _____

Signature of Patient/Legal Guardian Date