CONSENT FOR USE AND DISCLOSURE OF YOUR HEALTH INFORMATION

Our purpose in asking you to sign this form is to document that we have informed you that this office may use and disclose any and all of your health information in our possession. The use and disclosure by this office of your Protective Health Information are necessary and will be used by this office in connection with your treatment, obtaining payment for treatment and services that our office provided to you. For more complete description of how we may use your Protective Health Information, please carefully review the Notice of Privacy Practices. This is available in our office upon request and available on-line.

You have the right to review these Practices prior to signing this consent. Please be advised that your health information may be updated from time to time. Any revisions will be made available to you. You have the right to revoke this consent at any time. If you with to revoke this consent, you must do so in writing.

By signing this consent form, I authorize Dr. Caroline D. Mathew to release to a third party, or its representative, including Medicare, Medicaid, BC/BS, commercial insurers, automobile no-fault insurers, worker's disability compensation insurers, employers, health maintenance organizations, preferred provider organizations, and managed care plans which may be responsible for payment in your case, or as required by law. Such information from my medical record is necessary in order to receive reimbursement for any billing rendered related to my treatment, including alcohol and drug abuse records are protected under the regulations in 42 CFH, Part 2. Any social service records or psychological service records including communications by this office to a social worker or psychologist, I authorize Dr. Caroline D. Mathew to release to individuals or agencies which may provide services for my case such as information to any independent auditors or reviewers retained by any third party payer, private health insurers, or any employer providing health insurance benefits to me and this independent auditor can analyze charges.

I further understand that my treatment may require more than one date of service; therefore, this consent shall carry full force and effect from the date of signature until I am discharged from

I hereby assign payment directly to Dr. Caroline D. Mathew the insurance benefits otherwise payable to me, but not to exceed the balance due to Dr. Caroline D. Mathew and her affiliates for charges for these services.

I authorize Dr. Caroline D. Mathew to retrieve medication history via Surescripts e-prescribing or MAPS (Michigan Automated Prescription Service)

I assume full financial responsibility for payment of all services provided to me, including any portion of my bill that is not paid by insurance, worker's disability compensation, or social agencies.

PATIENT SIGNATURE: ______________________________________ DATE: ____________