Lehigh Valley Health Network
A PASSION FOR BETTER MEDICINE

AUTHORIZATION OF TREATMENT/ASSIGNMENT OF BENEFITS/ RELEASE OF INFORMATION/PRIVACY NOTICE

PATIENT:		DOB:	MEDICAL RECORD #:
DATE:	TIME:	LOCATION: LVPG Family and Internal Medicine - Bath	

CONSENT FOR TREATMENT: By this document, I do hereby request and authorize LVPG (Lehigh Valley Physician Group), its medical practices and providers including physicians, technicians, nurses, and other qualified personnel to perform evaluation and treatment services and procedures as may be necessary in accordance with the judgment of the attending medical practitioner(s). I acknowledge that no guarantee can be made by anyone concerning the results of treatments, examinations or procedures.

PRIVACY NOTICE: I acknowledge receipt of the Health Information Privacy Notice for Lehigh Valley Health Network & the Common Medical Staff of Lehigh Valley Hospital & Lehigh Valley Hospital-Muhlenberg on or after 04/14/03.

INSURANCE AUTHORIZATION AND ASSIGNMENT: I request that payment of authorized medical benefits is made on my behalf directly to the LVPG provider of service(s) furnished to me. I authorize LVPG to release any medical information to my health insurance carrier and/or its legitimate agents that is necessary to process related health insurance claims and/or to verify plan benefits in accordance with HIPAA health information standards. I authorize payment of service(s), otherwise payable to me under the terms of my private, group employer's or group health insurance plan, directly to LVPG. I hereby authorize that photocopies of this form to be valid as the original.

PAYMENT GUARANTEE: I do hereby guarantee payment of all fees and charges related to all services and durable goods provided to me through LVPG medical practices and providers from my first date of examination or treatment. I agree to make full payment immediately upon receipt of an LVPG billing statement whether it is an interim or final bill. In the event that I fail to make full payment or fail to comply with other payment arrangements made with LVPG's approval, I understand that appropriate collection measures may be initiated.

ELECTRONIC HEALTH RECORD: Healthcare providers require access to patient medical information whenever or wherever a patient presents for care to assure safety, quality and to coordinate patient care across the provider network, avoiding duplication of services. LVHN has a system-wide electronic medical record that is available to caregivers on a "need to know" basis, to share information about patient care provided in the hospital, outpatient or physician office settings. Confidentiality of records including those reflecting treatment for behavioral health issues, HIV/AIDS or drug or alcohol problems is maintained per relevant governmental and regulatory standards. Patient care summaries are automatically sent to designated LVPG and other community primary care/family/referring physicians, as well as to physicians who are consulted by the attending physician for coordination of care. LVHN and/or the attending physician can furnish and release to federal and state healthcare oversight agencies, or upon written request, to all insurance companies or their representatives any information with respect to treatment of the patient herein named including copies of the medical record.

ELECTRONIC PRESCRIBING: I understand that LVPG medical practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my LVPG providers and my pharmacy. I have been informed and understand that LVPG providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my LVPG providers to see this health information.

IMMUNIZATION REGISTRY: I understand that LVPG participates in the Pennsylvania Dept. of Health's statewide immunization registry that collects vaccination history and information to serve the public health goal of preventing the spread of vaccine preventable diseases. The registry complies with federal health information privacy laws.

RELEASE OF RESPONSIBILITY FOR PERSONAL VALUABLES: I have been made aware and understand that all LVPG medical practices and offices provide no facilities for safekeeping of valuables. I do hereby release LVPG from any responsibility due to loss or damage of any valuables that I, or anyone accompanying me, may bring to an LVPG medical practice, office or facility.

PERMISSION TO FAX CHILDHOOD IMMUNIZATION RECORD TO SCHOOLS: I do hereby grant permission for LVPG to send or fax childhood immunization records to schools, upon request.

I, or my legal representative, certify that I have read this document, that it has been fully explained to me and that I understand its contents, and hereby agree to all terms and conditions set forth above and acknowledge the receipt of a copy if requested

Signature of Patient or Parent/Legal Guardian/Authorized Representative

Relationship to Patient if Applicable

Witness to Signature

Date of Signing

06/10/2011version

LVPG Medical Information Communication Preferences

Patient ______________________________ MR#________________________ DOB ___/___/___

As our patient, we may need to reach you when you are not in the practice. For your privacy, please indicate your preferred method for us to communicate confidential medical information, such as test or lab results, to you and/or others involved in your care. Please note that "appointment reminder telephone calls" may be left at the contact number(s) you list below. Please list your email address to receive online health care educational programs ordered by your care provider.

PLEASE INDICATE YOUR COMMUNICATION PREFERENCES BELOW:

☐ I give permission to **leave medical information** pertaining **to me, my dependent or child**, at the numbers listed below:

Method	Yes	No	Area Code, Phone #, Ext, E-MAIL
Home telephone			
Answering Machine			
Work Phone			
Cell Phone			
E-MAIL for our Patient Portal secure email registration			
E-MAIL to receive provider-ordered online patient education programs			
Pager			

Without specific permission, we will **not** release any medical information to anyone other than you. In some cases you may wish for another person to have access to your medical information. Please identify those individuals and their relationship to you (i.e. spouse, parent, son, daughter, partner etc.):

☐ Do **not release medical information** to anyone other than myself.

☐ I give **permission to release medical information** pertaining to me to the individuals listed below.

Name	Relationship (i.e. spouse, parent, son, daughter, etc.)	Area Code, Phone # - Extension

Comments

I assume responsibility to inform the practice of changes in my phone number(s) or my preferences or to revoke this specific medical information authorization at any time.

______________________________________ ____________________

Signature of Patient or Patient's Legal Representative Date

______________________________________(Please Print Signer's Name)

LVPG Preferencia de Información Medica

Paciente ______________________________ MR#__________ Fecha de Nacimiento ___/___/___

Como nuestro paciente, nosotros quizás necesitaremos comunicarnos con usted cuando no este en la practica. Para proteger su privacidad, nos gustaría que usted nos indique su método de preferencia para poder comunicarle información sobre su salud a usted y a los que estén envueltos en su caso. Por favor mantenga en mente que un "recordatorio de su cita" no es clasificado como información de salud.

PORFAVOR INDIQUE SU PREFERENCIA DE COMUNICACION:

☐ Yo doy permiso **para que dejen información de salud** relacionado a mi persona, a mi dependiente o hijo(a) a los siguientes números de teléfono.

Método	Si	No	Código de Área, Numero #, Extensión
Casa			
Grabadora de Mensajes			
Teléfono del Trabajo			
Celular			
Beeper			

Sin un permiso en específico, nosotros no le daremos información a nadie sobre su salud a menos que sea a usted. En algunos casos usted puede permitir que otra persona obtenga acceso a su información de salud. Por favor identifique a esto individuos y su relación con usted (por Ej.: esposo(a), padres, hijos, compañero(a), etc.)

☐ No **le permito a nadie obtener información** de mi salud a menos que sea a mi persona.

☐ Doy **permiso para que las siguientes** personas en esta lista obtengan información sobre mi salud.

Nombre	Relación (Ej.: esposo(a), padre, hijo, hija, etc.)	Código de Área, Numero # - Extensión

Comentarios:

Asumo la responsabilidad de informarle a la oficina de cualquier cambio con mi número de teléfono, mis preferencias, o en cualquier momento revocar esta autorización en específica sobre la información de mi salud.

______________________________ ______________

Firma del Paciente/ Representante Legal Date

______________________________ (Por favor imprima su nombre)

Interpreters Dept. 17th/JM

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