Dr. Sean W. Lazarus DPM, Medical Director

WEST HAVEN FOOT AND ANKLE CENTER

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Patient Name *(please print)*: _____

Patient's Guardian *(if applicable, print)*: _____

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize Dr. Sean W. Lazarus DPM to use and disclose my individually identifiable Protected Health Information ("PHI") in the manner described below. I understand that my PHI may be re-disclosed by the person or entity receiving it and that it then may no longer be protected by federal privacy regulations. State law may or may not prohibit re-disclosure by the person or entity receiving my PHI. I voluntarily agree to this authorization, and I understand that my health care will not be affected if I do not sign this form.

I hereby authorize use of my PHI for the purpose of diagnosing, treating, consulting, and referral.
I hereby authorize the disclosure of my PHI to insurance carriers and/or its representatives for processing claims.
I acknowledge that I have read, understand, and have been offered a copy of the full HIPPA policy.

By my signature, I acknowledge that I have read and understand the Authorization for Use and Disclosure of Protected Health Information.

Patient or Guardian Signature: _____ Date: _____

ASSIGNMENT OF BENEFITS

I hereby authorize payments to be made directly to Dr. Dean W. Lazarus, DPM for surgical and/or medical benefits, if any, otherwise payable to me for professional services rendered. I understand that I am financially responsible for the charges not covered by this Authorization. I further agree in the event of non-payment to bear the cost of reasonable legal fees should this be required. A photocopy of this assignment shall be considered as effective and valid as the original.

By my signature, I acknowledge that I have read and understand and have been offered a copy of the Assignment of Benefits.

Patient or Guardian Signature: _____ Date: _____

CONSENT FOR TREATMENT

The information I provided is true to the best of my knowledge. I hereby give permission to the physician or his assistant(s) to initiate the diagnosis and treatment of my condition with examination, imaging studies, and/or photographs as deemed medically relevant and necessary. I also authorize the release of any previous medical records by fax, mail, electronic mail, or phone to either another treating physician or hospital as needed.

By signature, I acknowledge that I have read and understand the Consent for Treatment

Patient or Guardian Signature: _____ Date: _____