Justin Pruitt, DO, MS

Patient's or Authorized Person's Authorization to Release Information and Assignment of Benefits

I, ____, as a patient (or Legal Guardian of a patient) of Flint River Family Medicine,P.C., hereby consent to treatment as may be deemed necessary or advisable in the diagnosis and treatment of my care.

I authorize the release of any medical information necessary to process any insurance claim on my behalf. I permit a copy of this authorization to be used in place of the original.

Signature____ Date_____________________________

I hereby authorize Flint River Family Medicine, P.C./Justin Pruitt, D.O. to apply benefits on my behalf for the covered services rendered by the office, or by the office's order. I request that payment from my insurance company be made directly to Flint River Family Medicine, P.C., Justin Pruitt, D.O. or to the party who accepts assignment. I certify that the information I have reported with regard to my insurance coverage is correct.

I acknowledge and agree that Flint River Family Medicine, P.C., and any affiliates or vendor thereof, including collection or billing companies, may contact me by telephone or text message using the numbers associated with my account, including wireless or mobile phone numbers. Furthermore, I agree that you may use any method to contact these numbers including Automated Telephone Dialing System (ATDS) or prerecorded message. I also agree that I will notify Flint River Family Medicine, P.C. if I have given up ownership or control on any such telephone number.

Signature____Date____________________________

Receipt of Privacy Practices

I was provided a copy of Flint River Family Medicine, P.C.'s Notice of Privacy Policies. Flint River Family Medicine, P.C. may revise its notification at any time. I understand that a copy is always available at my request. By signing this document, I acknowledge that I have read, understand, and agree to the terms of this consent. Further, I hereby consent and authorize Flint River Family Medicine, P.C. to use or disclose my PHI in conjunction with treatment, payment, or healthcare operations in accordance with the terms of this consent.

Signature____Date____________________________

Consent for Disclosure of Protected Health Information (PHI)

This form authorizes the physicians and staff of Flint River Family Medicine, P.C. to discuss my PHI, with the person(s) stated below--including the authorization to discuss appointment times, referrals, results, etc. and/or to pick up prescriptions, letters, or forms on my behalf. I understand by electing to list no one on my disclosure, that I will be the only person who may obtain information or pick up prescriptions and/or letters from this office.

Name of Person(s):	Relationship to Patient:
_____________________________________	_____________________________________
_____________________________________	_____________________________________
_____________________________________	_____________________________________
_____________________________________	_____________________________________

I understand this Consent for Disclosure of Protected PHI is valid until I complete a new form; I may cancel this authorization by sending a letter to the office or completing a new form.

Signature____Date____________________________