ASSIGNMENT OF BENEFITS

Private insurance authorization for assignment of benefits and information release:

I, the undersigned, authorize payment of medical benefits to Bee Well **PEDIATRICS of Central Texas** for any services furnished to my child by the physician. I understand that I am financially responsible for any amount not covered by my insurance policy. I also authorize Bee Well Pediatrics of Central Texas to release to my insurance company, referring physician, or any other consultants on my case, information concerning health care, advice, treatment, or supplies provided to me. This information will be used for the purpose of evaluating and administering claims benefits.

____
NAME OF PATIENT (PLEASE PRINT)

____ ______________________
SIGNATURE OF LEGAL GUARDIAN DATE

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

By signing this document, I acknowledge that I have been given the opportunity to read the Notice of Privacy Practices of Bee Well **PEDIATRICS of Central Texas.**

____
NAME OF PATIENT (PLEASE PRINT)

____ ______________________
SIGNATURE OF LEGAL GUARDIAN DATE

PHOTOGRAPH AUTHORIZATION

I hereby authorize Bee Well **PEDIATRICS of Central Texas** to take this patient's photograph for inclusion in his/her medical chart retained by the clinic. I understand this photograph will be used for the purposes of identification and familiarization by the office staff, clinic physician(s), and consulting physicians. It may also be used on consult letters that we send to your child's other physicians.

____
NAME OF PATIENT (PLEASE PRINT)

____ ______________________
SIGNATURE OF LEGAL GUARDIAN DATE

12005 BEE CAVE RD #2A | AUSTIN, TEXAS 78738 | 512.225.0766 | BEEWELLAUSTIN.COM

AUTHORIZATION FOR THE USE OR RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT INFORMATION

NAME OF PATIENT (PLEASE PRINT) ____________________

DATE OF BIRTH ____________________

CURRENT STREET ADDRESS ____________________

SOCIAL SECURITY NUMBER ____________________

CITY ____________________ STATE ____________________ ZIP ____________________

CURRENT PHONE NUMBER ____________________

EMAIL ADDRESS ____________________

ALTERNATE PHONE NUMBER ____________________

PREVIOUS AND/OR CURRENT PHYSICIANS

PRACTICE NAME ____________________

PHYSICIAN'S NAME ____________________

STREET ADDRESS ____________________

CITY ____________________ STATE ____________________ ZIP ____________________

PHONE NUMBER ____________________

FAX NUMBER ____________________

I authorize release of the following medical record information for the above named patient:

- ☐ **COMPLETE HEALTH RECORDS**
  (which will include all of the following)

OR

- ☐ IMMUNIZATIONS
- ☐ HISTORY & PHYSICAL REPORTS/FILMS
- ☐ RADIOLOGY
- ☐ OPERATIVE REPORTS
- ☐ LABORATORY REPORTS
- ☐ ALL NUCLEAR
- ☐ PROGRESS NOTES
- ☐ DISCHARGE SUMMARY
- ☐ PATHOLOGY REPORTS
- ☐ OTHER (PLEASE SPECIFY) ____________________

This information is to be disclosed for the purpose of MEDICAL CARE.

I hereby authorize the above named Practice(s) and Physician(s) to release the medical records of the above named patient to Bee Well **PEDIATRICS of Central Texas.** I understand that this authorization may be revoked at any time, except to the extent that action has been taken in reliance on this authorization. This authorization will automatically expire in ninety (90) days from the date of signature.

(PLEASE PRINT YOUR NAME) ____________________

(PLEASE SIGN YOUR NAME) ____________________

DATE ____________________

NAME OF PATIENT (PLEASE PRINT) DATE OF BIRTH

I understand and agree to pay a reasonable copying fee to cover the cost of medical record transfer. I further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy and information to be used or disclosed under this authorization. I understand that provider's records may contain information created by an entity other than Bee Well **PEDIATRICS of Central Texas** and therefore is not responsible for the information contained in such incorporated information (including the accuracy, completeness, relevance, legibility or lack thereof of such incorporated records). I expressly request release of all records maintained by Bee Well **PEDIATRICS of Central Texas** concerning the above named patient, including incorporated records. I acknowledge that Bee Well **PEDIATRICS of Central Texas** has no and assumes no duty to me regarding the content of or omission from such incorporated records.

I hereby release Bee Well **PEDIATRICS of Central Texas** and its personnel from all legal responsibility of liability that may arise from the act I have authorized above. Bee Well **PEDIATRICS of Central Texas** is not responsible for completeness, legality, or omissions caused by the copying of any medical records from another institution.

(PLEASE PRINT YOUR NAME) (PLEASE SIGN YOUR NAME) DATE

RELATIONSHIP TO PATIENT

☐ Legal guardian declines authorization for the release or use of protected health information.

DATE INITIALS