PHYSICIAN HOUSECALLS

Compound Authorization Form

Patient's Name_____ DOB_____

Please strike through any of the sections below that you do NOT wish to authorize.

I authorize the release of my medical records to ***PHYSICIAN HOUSECALLS*** upon its request, including all examinations, diagnoses, laboratory and imaging studies, and treatments for the past two years.

Release from: _____

(Current or previous physician (including specialists) or facility releasing information)

Phone: (_____)_____-_____ Fax: (_____)_____-_____

Release from: _____

(Current or previous physician (including specialists) or facility releasing information)

Phone: (_____)_____-_____ Fax: (_____)_____-_____

I request and authorize medical care by Physician Housecalls providers as described in the General Consent for Treatment attachment.

I authorize payment of my medical benefits to ***PHYSICIAN HOUSECALLS*** for services rendered.

I authorize ***PHYSICIAN HOUSECALLS*** to exchange information necessary for payment.

I acknowledge I have been offered and/or received the Physician Housecalls Notice of Privacy Practices.

I understand and agree that I am financially responsible for all charges of services rendered to me, including balances owed after insurance payments.

I authorize ***PHYSICIAN HOUSECALLS*** to discuss my medical care, etc., with the followingindividual(s):_____,_____,

_____,_____,_____.

I give consent to the electronic download and review of medication insurance eligibility and medication history. Note: ***PHYSICIAN HOUSECALLS*** will check all patient's medication histories.

_____ _____

Signature of patient or patient's Power of Attorney **Date**

_____

Printed Name

Please note that ONLY this completed form with signatures should be returned to Physician Housecalls.
Please fax to (855) 223-1999 or email to referrals@housecallsok.com.