



**Release of Information & Assignment of Benefits**

**Commercial Insurance**

I hereby authorize the release of the medical information necessary to file a claim with my insurance company and assign benefits otherwise payable to me.

I understand I am financially responsible for any balance not covered by my insurance carrier. A copy of this signature is as valid as the original.

Signature of patient or guardian \_\_\_\_\_

**Medicare Insurance**

Beneficiary \_\_\_\_\_ Medicare Number \_\_\_\_\_

I requested that payment of authorized Medicare benefits be made either to me or, on my behalf, to Dr. \_\_\_\_\_ for any service furnished to me by that physician. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits payable for related services.

Beneficiary Signature \_\_\_\_\_

**Medicare Supplemental Insurance**

Beneficiary \_\_\_\_\_ Medicare Number \_\_\_\_\_  
Medigap ID Number \_\_\_\_\_

I request that payment of authorized Medigap benefits be made either to me, or on my behalf, to \_\_\_\_\_ for any service furnished to me by that physician. I authorize any holder of medical information about me to release to Medigap insurance carrier any information needed to determine these benefits payable for related services.

Beneficiary Signature \_\_\_\_\_

Medicare Signature on File

I request that payment of authorized Medicare benefits be made on my behalf to **TrueMedicine**, for services furnished me by **TrueMedicine**. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the CMS 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown.

(practitioner's name) accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

\_\_\_\_\_  
(patient's signature)

\_\_\_\_\_  
(date)



We reserve the right, as legally permitted, to amend or modify our privacy policies and practices. These changes in our policies and practices may be required because of changes in federal and state laws and regulations. Upon request, we will provide you with the revised notice at the time of your office visit. These will be applied to all protected health information we maintain.

### **Requests to Inspect Protected Health Information**

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may request access to your records by contacting our receptionist or privacy official. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

For more information about HIPAA:

US Department of Health & Human Services  
202-619-0257  
Toll Free: 1-877-696-6775