I hereby acknowledge that I have been presented with a copy of the Bozeman Creek Family Health notice of Privacy Practices.

Patient/Guardian Signature: ________________________________**Date**: _______
Print Patient Name: ____
Relationship to patient: Self, Parent, Guardian, Responsible Party, Legal Representative, etc____

Authorization to Disclose Health Information

As a patient of Bozeman Creek Family Health, you are protected under The Health Insurance Portability and Accountability Act of 1996 (HIPAA). We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

I authorize ____ to inquire about:
(Print name of: parent, significant other, spouse, family member, etc.)

Please check all that apply:

☐ Payments/Charges

☐ Health Information (prescriptions, test results)

☐ Consult with my Doctor regarding my healthcare

Patient Signature: ____**Date:** ________

Insurance Authorization

I hereby authorize Bozeman Creek Family Health to furnish information to my insurance carriers concerning my illness and treatments. I also authorize payments of insurance benefits to be made directly to Bozeman Creek Family Health. I understand that I am responsible for all charges incurred.

Patient/Guardian Signature: ________________________________**Date**: ________
Print Patient Name: ____
Relationship to Patient: Self, Parent, Guardian, Responsible Party, Legal Representative,etc____