WESLEY CHAPEL DERMATOLOGY

2336 CRESTOVER LN 101, WESLEY CHAPEL FL 33544

Authorization to Release Information

I hereby authorize Wesley Chapel Dermatology, its affiliates, and Physicians using and sharing all my health information, for payment, my continued treatment, and healthcare operations. This includes sharing my information with the following:

- All physicians and other medical service providers associated with my treatment
- Business partners of the Medical Group, its affiliates, and Physicians, who provide administrative, operational, financial, legal, and technical support services
- All insurance Payer(s) and healthcare plans responsible for paying or determining if I am eligible for payment for my treatment

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Wesley Chapel Dermatology, medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance

If you have a supplemental policy and it's a MEDIGAP policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file. Please read and sign the following statement "I authorize MEDIGAP benefits to me made on my behalf for any services furnished to me. I authorize the holder of information to release to the above MEDIGAP carrier information to determine these benefits payable for related services.

Medication History Download

I understand and I give my consent to retrieve and review my medication history. I understand that this will become part of my medical record. A medication history is a list of medicines that these providers and other health providers have recently prescribed for a patient. It is collected from a variety of sources, including, a patient's pharmacy, health plans, and other health providers

Patient Name: _____ DOB: _____

Guarantor Name (For Minor): _____

Signature Patient/Guarantor: _____