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A Division of Millennium Medical Professionals, P.L.L.C.

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PRACTICE LIMITED TO CARDIOVASCULAR DISEASES

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AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION, ACKNOWLEDGEMENT OF RECEIPT OF HIPAA PRIVACY LAW & FINANCIAL LIABILITY FORM

I give authorization to disclose my protected health information to the following:
PLEASE NOTE: If no one is listed, information will be given only to you

NAME	RELATIONSHIP	TELEPHONE
_____	_____	_____
_____	_____	_____
_____	_____	_____

I understand that I may revoke this authorization at **any** time by giving my written notice to the Privacy Officer at Millennium Medical Professionals. I understand I do not hold Millennium Medical Professionals responsible for any actions taken **BEFORE** receipt of my written revocation of this form.

In order to submit a claim for payment to us for services covered under your policy, we must have your authorization to release medical information to your insurance carrier.

MEDICARE

Name of Beneficiary:_____ **HI Claim No.:**_____

I request that payment of authorized Medicare benefits be made directly to Millennium Medical Professionals (Drs. Ganguly/Geller/Malhotra/Rosenband/Cohen/Khan/Borek/Mozes) for any services furnished me by these physicians. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I hereby authorize Medicare to furnish to the above named doctor any information regarding my Medicare claims under Title XVIII of the Social Security Act.

COMMERCIAL INSURANCE

I hereby authorize release of information necessary to file a claim with my insurance company and ASSIGN BENEFITS OTHERWISE PAYABLE TO ME TO THE DOCTOR OR GROUP INDICATED ON THE CLAIM.
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.

I am aware that my insurance may have certain guidelines I must follow in the event that my condition may require surgery and that I have been for non-emergency tests performed outside of the frequency prescribed by my physician. I agree to be personally responsible for payment of any denied claims. I acknowledge that I have received a copy of the notice of privacy practices for Millennium Medical Professionals.

Patient Signature: _____ Date _____

Print Name: _____