NYSS
NEW YORK SPEECH SOLUTIONS

CONSENT FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize NY Speech Pathology Consultants, P.C. to release information to my primary care physician/consulting physicians, medical providers as well as my family/designated representative. I understand that the information to be released is confidential and protected from disclosure. I also understand I have the right to cancel my permission to release information at any time.

_____ _____

Patient (or Authorized) Signature Date

ASSIGNMENT OF BENEFITS

I authorize payment of Medicare/other Insurance benefits to NY Speech Pathology Consultants, P.C. for services furnished to me.

I also authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services (CMS) and other insurance carriers any information necessary to process claims. If I am enrolled with a Home Health Care Agency now or during my treatment with NY Speech Pathology Consultants, P.C., Medicare will not pay for my services, and I will be responsible for payment to NY Speech Pathology Consultants, P.C.

_____ _____

Patient (or Authorized) Signature Date

_____ _____

Name of Patient Date

Enrolled in HHA _____ Date Completed _____

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