**Authorization to Treat**

Your privacy is important to us. Upon request, a printed copy of the AloeWell Health HIPAA Notice of Privacy Practices is available for your review. If you have requested and received a copy, your signature below indicates the date of receipt. If you have already received a copy and are declining a duplicate copy, your signature below indicated date of refusal.

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby authorize the staff of AloeWell Health to provide me with medical treatment or services. I agree to inform AloeWell Health if I have any concerns about my medical treatment or services at the time services are being rendered.

We/I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, the parent(s)/ guardian (s) of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ give AloeWell Health and its employees the right to treat my son/ daughter or legal ward.

**Release of Information**

The medical records concerning patient care are the property of AloeWell Health and are maintained for the benefit of the patient, the medical staff and the practice. I hereby authorize AloeWell Health to release information and/or copies of my medical records to physicians, any guarantor of payment on my account (and other third party payors; Department of Transportation physical examination as applicable) for which I have assigned benefits for my treatment or care. The patient information, including patient information of psychiatric and/or psychological care, alcohol and/or substance abuse, and serologic test results (including, but not limited to, Acquired Immune Deficiency Syndrome or positive HIV results). I authorize AloeWell Health to use all available means of communication to transmit such information, including electronic mail or electronic facsimile. I may revoke this authorization at any time by notifying AloeWell Health in writing. This revocation, however, would not apply to information already released in response to this authorization. I understand that AloeWell Health will not condition treatment or payment on my providing this authorization.

**Assignment of Benefits**

The undersigned, whether signing as a patient, representative or guarantor, hereby authorizes direct payment of any insurance benefits otherwise payable to or on behalf of the patient to AloeWell Health. I hereby assign to AloeWell Health all medical benefits otherwise payable to me by virtue of my visit to AloeWell Health. I hereby will pay such benefits directly to AloeWell Health in consideration of the professional services rendered to me or my insured dependent or any insured person designated in my policy. I understand I will be responsible for payment of services not covered and/or denied by health insurance.

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**