Superior Med, LLC
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Patient Authorization

I authorize the use and/or disclosure of my protected health information (PHI) by the following methods:

Home Phone#/ Leave message _____	____Yes	____No
Cell Phone#/ Leave message _____	____Yes	____No
Text message	____Yes	____No
Work Phone#/ Leave message_____	____Yes	____No
Mail	____Yes	____No
E-mail Address(Used for Patient Portal)_____	____Yes	____No
Fax Records to the insurance company, referring physician, Specialist and/or any physician involved	____Yes	____No

Other preferred Method_____

I authorize the following people to receive my protected health information:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

I _____SS# _____ understand that by signing this authorization:

- I consent to treatment necessary for the care of the above named patient
- I authorize the release of all medical records to the referring and family physicians, Superior Med, LLC and to my insurance company, if applicable
- I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment
- I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges
- I further authorize and request that insurance payments be made directly to **Superior Med, LLC** should they elect to receive such payment
- I authorize the above as an authorized representative on my patient portal

I have read and fully understand the above consent for treatment, financial responsibility, release of medical information, and insurance authorization.

Signature:_____ Date:_____

Witness:_____ Date:_____

Superior Med, LLC is vigilant to protect patient confidentiality. No information is shared or distributed with any other persons or organizations without signed authorization.

12/2015