PAUL W. DAUM, M.D. Mansfield Miracles
Obstetrics – Gynecology – Infertility
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AUTHORIZATION TO RELEASE INFORMATION

Paul W. Daum, M.D. may disclose all or part of this patient's record to any insurance company, association, or the Federal of State Government as may be necessary for the completion of all medical claims.
I understand that the information to be released may include information pertaining to mental or psychiatric related conditions and/or drug or alcohol abuse. A copy shall be as valid as the original. I understand that I have the option to revoke this authorization at any time.
I hereby authorize payment to Paul W. Daum, M.D. benefits specified and otherwise payable to me for any services rendered by Paul W. Daum, M.D. subsequent to this date and for such other charges as may be made by said doctor.
I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorized any holder of medical or other information about me to release to the Social Security Administration of its intermediaries or carriers any information needed for this related medical claim. I request that payment of Authorized Benefits be made on or in my behalf to Paul W. Daum, M.D.
I, the undersigned, certify that I have read the foregoing, and am the patient, or am duly authorized by the patient as the patient's general agent to execute the above and accept its items.

ACKNOWLEDGEMENT OF REVIEW NOTICE OF PRIVACY PRACTICES

I have reviewed this office's Notice of Privacy Practices, which explain how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

PATIENT PRIVACY POLICY

We have identified the problem that, during check-in and check-out, you may overhear things said by other patients, or they may overhear things that you say. Due to the configuration of our office, there is nothing that we can reasonably do to change this. We will make a good faith effort to preserve your privacy at all times by taking your history in exam rooms, the nurses' station or the physician's private office and not discussing issues of a personal nature in public areas. Please cooperate with us by ceasing to speak of personal issues if you notice another patient of family member is approaching in the hallway or stopping at the desk.

I have read, understand and acknowledge the above information which shall remain in my current file unless revoked by me and that I may revoke this release at any time.

Patient's Signature____

Signature of Patient's Representative____________________Relationship____________

Witness Signature____

Date__________Date__________Date__________Date__________Date__________

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