Consents and Assignments

PERSONAL REPRESENTATIVE, FAMILY OR OTHER ENTITY AUTHORIZED ACCESS TO PROTECTED HEALTH INFORMATION: Name the persons you are authorizing Choptank Community Health System, Inc. to disclose your protected health information regarding treatment, payment and other healthcare operations in the event you are not available.

Name of Authorized Person	Relationship	Phone Number
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RELEASE OF INFORMATION: I authorize Choptank Community Health System, Inc. to release information from my medical record to any person, corporation or agency legally responsible for processing and/or paying of any part of the center's charges and/or professional fees. I also authorize release of healthcare workers/providers/consultants who are involved in my care. Release of information to any other party other than that stated above will require separate authorization.

ASSIGNMENT OF BENEFITS: In the event that I am entitled to benefits arising out of my medical insurance policy or contract of insurance benefits, I assign these benefits to Choptank Community Health System, Inc. I also assign benefits payable for physician services to Choptank Community Health System, Inc. I further understand that I am responsible for 'non-covered' charges by my insurance and/or for charges incurred without authorization or referral.

CONSENT FOR CARE: I hereby give consent to the providers of Choptank Community Health System, Inc. to examine, make an assessment and recommend the appropriate treatment for my condition. I also consent to the collection and testing of specimens required for the diagnostic evaluation of my symptoms/condition.

RIGHTS AND RESPONSIBILITY: I have received and read a copy of Choptank Community Health System, Inc. "Notice of Information Privacy Practices" HIPAA Notification.

Printed Name: _____ Date of Birth: _____

Signature: _____ Date: _____