



General Permissions Form

DO WE HAVE YOUR PERMISSION TO?

- Leave test results or appointment confirmations on your answering machine at work? YES NO
- Leave test results or appointment confirmations on your answering machine at home? YES NO
- Leave test results or appointment confirmations on your cell phone voice mail? YES NO
- Fax copies of your results to another physician if necessary? YES NO
- Would you like appointment reminders through email? YES NO

Initial here _____

I allow PrimeCare Medical Group to view my prescription history from an external source, due to continuing patient care. _____ Initial here

For Self Paid (non Insured) Patients:

I certify that I do not have insurance benefits and that I will not be filing to an insurance company for reimbursement of these charges. _____ Initial here

For Insured Patients:

I authorize release of any medical or other information necessary to process my insurance claims. I certify that the information I furnish is true and correct. _____ Initial here

I authorize payment of medical benefits to PrimeCare Medical Group. I understand that I may be responsible for any amount not paid by my insurance company if they are deemed non-covered items. _____ Initial here

Signature of Patient or Personal Representative

Date

Print Name

Relationship to Patient