

**Comprehensive Hand Surgery
Mukund Patel, MD
4901 Fort Hamilton Parkway
Brooklyn, NY 11219**

1. Authorization to Release Medical records to my insurance company for payment of Dr. Patel's medical fees.

I authorize Dr. Mukund Patel, MD to release (disclose) all or part of my records necessary to ensure payment on any claim, to hospital or medical service companies, insurance carriers, welfare funds, patient's employer and/or any third party payer.

SIGNATURE

PRINT NAME

DATE

2. Medicare Release For Medicare Patients Only

I am giving Dr. Mukund Patel, permission to ask Medicare for payments for my medical care. I authorize him to release to the Center for Medicare Services and/or any third party payer and/or its agents, intermediaries or carriers any information needed to determine Medicare benefits or the benefits payable for related services. I request that payment of authorized benefits be made on my behalf to Comprehensive Hand Surgery, P.C. for any services furnished by Dr. Patel. I authorize Dr. Patel to release to the Center for Medicare Services information needed to determine these benefits or the benefits payable for related services. I also understand that Dr. Patel will be submitting a claim for payment on my behalf.

SIGNATURE

PRINT NAME

DATE

3. Acknowledgement of Receipt of notice of Patient Privacy from Dr. Mukund Patel.

By my signature below, I hereby acknowledge receipt of Notice of Privacy Practices, and I acknowledge that the Dr. Patel will use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting health care operations.

I have been advised of my rights to obtain access to and control my Protected Health Information.

SIGNATURE

PRINT NAME

DATE

4. I understand that I am responsible for any payment not covered by Medicare, my insurance company or worker's compensation insurance company and will provide payment upon request.

SIGNATURE

PRINT NAME

DATE