Name DOB **AUTHORIZATION FORM**

*MOTOR VEHICLE INSURANCE / LABOR & INDUSTRIES / THIRD PARTY

DATE OF INJURY/ACCIDENT	EMPLOYMENT RELATED? ☐YES ☐NO	ACCIDENT ☐AUTO ☐NON-AUTO ☐N/A	CAUSE OF ACCIDENT
CLAIM NUMBER	CLAIM ADJUSTER NAME	CLAIM ADJUSTER PHONE	
CLAIMS MAILING ADDRESS			

AUTHORIZATION

It is our responsibility to protect your medical records and we do not provide any information regarding you or your medical conditions without your written consent. Please note any changes below of the people (doctors, family, etc.) with whom you authorize us to discuss your medical conditions.

NAME	RELATIONSHIP	PHONE NUMBER
NAME	RELATIONSHIP	PHONE NUMBER
NAME	RELATIONSHIP	PHONE NUMBER

PHONE CALLS/MESSAGES

We often call patients for the reasons listed below. Please mark which number we may call to leave messages.

Is it OK to leave a message to confirm your appointment?
☐ Home ☐ Cell ☐No, do not call to leave a message at the home or cell number

Is it OK to leave a message with results of lab or imaging studies?
☐ Home ☐ Cell ☐No, do not call to leave a message at the home or cell number

Is it OK to MAIL the results of lab or imaging studies to your home address?
☐Yes ☐No

PHARMACY

MAIL ORDER PHARMACY? MAIL ORDER PHARMACY NAME
☐YES ☐NO

PREFERRED PHARMACY? PREFERRED PHARMACY NAME PREFERRED PHARMACY PHONE
☐YES ☐NO

PAYMENT / CONSENT TO TREAT

I authorize Overlake Medical Clinics, LLC to release any and all information required to process an insurance claim for payment as allowed by law.

I authorize the medical and other staff of Overlake Medical Clinics, LLC permission to employ such established treatments and therapies deemed professionally and medically necessary or advisable in the diagnosis and treatment of my health problems. I understand that medical care may be given by a Physician, Nurse Practitioner, Physician Assistant or other licensed staff. This authorization shall remain in effect unless the consent is cancelled by written notice to the Medical Director.

I authorize payment of medical benefits to be paid directly to Overlake Medical Clinics, LLC for services received. I understand that I am financially responsible for any balance due.

My signature acknowledges understanding and consent to this information.

_____ _____

Signature Date

Updated 9/26/12