Authorization and Consent Form

AUTHORIZATION OF CARE:
I hereby authorize Lake Street Family Physicians and staff to examine me and perform tests and procedures as they feel in their best judgment are reasonable and necessary in the diagnosis and treatment of my case. I acknowledge that no guarantees will be made to me as to the result of my treatment and/or examinations.

AUTHORIZATION TO RELEASE INFORMATION:
I hereby authorize Lake Street Family Physicians and staff to furnish to my health insurance company and/or insurance company's review agency, or other third party insurance payor(s) or their designated agents, all the information the above named entities may request concerning treatment for myself and my dependents, including medical records.

AUTHORIZATION TO ASSIGN INSURANCE BENEFITS:
I hereby authorize Lake Street Family Physicians and staff the medical and/or surgical benefits to which I, or my dependents, are entitled under my health insurance plan. I guarantee payment in full for all amounts not covered by my health insurance company or other assigned third party payor(s). **I understand I will be responsible for payment of all co-pays, deductibles and non-covered services.**

CONSENT TO ELECTRONIC PHARMARY BENEFITS DATA EXCHANGE:
I hereby consent to enable Lake Street Family Physicians to obtain prescription formulary information and medications prescribed by any provider using Surescripts RxHub.

CONSENT TO IMMUNIZATION REGISTRY:
Immunization data may be reported to the State of Illinois Registry without the specific written authorization of patient or guardian. The patient or guardian or legal custodian may have the patient's record excluded from the Registry by completing Illinois' Immunization Registry Opt-Out Registry Form (Op-Out Form) and submitting the completed form to the provider.

I have read this form and understand its contents.

Patient Name (PRINT): ____

Signature: ________________________________ Date: _________________

Name and Relationship to patient: _______________________________________
(If signing on behalf of patient)