

Doctors Making Housecalls

FAX TO: 919-933-6881

Phone: 919-932-5700

_____ I authorize the release of my medical records to *Doctors Making Housecalls* upon its request, including all examinations, diagnoses, laboratory and imaging studies, and treatments for the past two years.

_____ I authorize payment of my medical benefits to *Doctors Making Housecalls* for services rendered.

_____ I authorize *Doctors Making Housecalls* to give my insurance company any information about services rendered to me as necessary to process claims.

_____ I acknowledge that I received or was offered the practice's *Notice of Privacy Practices* describing the use and disclosure of confidential healthcare information.

_____ I understand and agree that I am financially responsible for all charges for services rendered to me, including balances owed after insurance payments.

Date

Signature of patient or patient's Power of Attorney

(Please print name above)

32405 Archdale, Chapel Hill, NC 27517