AUTHORIZATION AND CONSENT TO USE AND DISCLOSE MEDICAL INFORMATION

The Medical Privacy Notice of Robert D. Weaver and Jennifer Zienkowski-Zubel provides information about how we may use and disclose confidential medical information
about you. You have the right to read our Notice before signing this Consent. The terms of our Notice may change from time to time. If we change our Notice, you may obtain a revised copy during your next visit.

By signing this Authorization, you agree to let us use and disclose confidential medical information about you for treatment, payment, and health care operations. This includes information about physical and mental illness, substance abuse or HIV/AIDS, if applicable. You are also consenting to the release of medical information about you to any insurer, third party payer, the Social Security Administration, or any agents or consultants who help this office get paid for you treatment and other health care operations.

Date _____

Patient Signature _____

Patient Name (Printed) _____

Patient's Parent or Legal Representative _____
(As applicable)

INSURANCE AUTHORIZATION

I hereby authorize Dr. Weaver/Dr. Zienkowski-Zubel to furnish information to insurance carriers concerning my illness and treatments, and hereby assign to the physician all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance and agree to pay for fees involving past due collections.

Signature: _____

You may obtain a complete copy of our privacy notice upon request.