TOTAL JOINT CARE

Authorization Form

Patient: _____
(Please Print Patient Name)

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

_____ I authorize the release of my medical records from *Total Joint Care* upon its request, to requesting providers for continuation of my care.

_____ I authorize payment of my medical benefits to *Total Joint Care* for services rendered.

_____ I authorize *Total Joint Care* 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 by *Total Joint Care* (attached).

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

_____ _____
Signature of Patient or Legal Guardian Date

_____
(Please print the signer's name)

Holly Springs Office – 104 Bass Lake Rd Holly Springs, NC 27540

Cary Office – 115 Parkway Office Court Suite 101 Cary NC 27518