Authorization Form

St. Peter Family Medicine
525 Lilly Road NE Olympia, WA 98506
(360) 493-7230 fax (360) 493-4180

PLEASE READ AND SIGN THE FOLLOWING STATEMENTS
THIS DOCUMENT WILL BECOME PART OF YOUR MEDICAL RECORD

Authorization for Treatment

I hereby authorize the administration of all procedures, medication, and anesthetics that may be considered necessary or advisable in the judgment of the St. Peter Family Medicine provider.

Authorization to Release Information

I hereby authorize St. Peter Family Medicine to release necessary medical information to any insurance carrier, or their representatives, for the purpose of processing St. Peter Family Medicine's claims for payment for services rendered to me or my dependents.

Confidentiality of Records

I understand that St. Peter Family Medicine will maintain confidentiality of my medical record including the physical chart, electronic records, and billing/account information. St. Peter Family Medicine uses electronic media to store certain patient information including secure portions of the Internet.

I certify that I have read, understand and agree with the above statement. I understand that this authorization is valid for one (1) year unless revoked in writing and that a copy is as valid as the original.

I, _____ have read and agree with the above statements.
Please print name and relation to patient

_____ _____
Signature Clinic Representative

_____ _____
Date Date

_____ _____
Patient Name Patient Date of Birth

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