Harris Plastic Surgery
500 Montauk Highway
Suite H
West Islip, NY 11795

AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS FOR NON-MEDICARE PATIENTS

I, _____, authorize and direct my insurance benefits to be paid directly to Dr. Stephen U. Harris, or his practice, Harris Plastic Surgery.

I also authorize Dr. Stephen U. Harris or Harris Plastic Surgery to release any information necessary to process this claim. I understand that information will be released to: the billing department of Dr. Stephen U. Harris and/or Harris Plastic Surgery and my insurance carrier to process my claim for services rendered. I understand that my information, under certain circumstances may be released for one of the following reasons:

- other health care professionals in order to coordinate my care or treatment
- insurance adjustor – if my claim is a work or motor vehicle injury
- employer – if my claim is related to a work injury
- attorney – if my claim is in a litigation process
- health insurance company, for chart audit reasons, not for claim payment

I understand that Dr. Stephen U. Harris and/or staff and the billing office will not release any information to myself or family members over the phone without verification of my identity in order to comply with privacy regulations. I also understand that Dr. Stephen U. Harris and his staff and the billing office will maintain the utmost respect for privacy. However, I also understand that there are physical constraints such as noise and the ability for others to overhear information, and other errors that may occur that may cause inadvertent dissemination of information, as well as the potential for confidential information to be disclosed after it has been provided to outside sources such as your insurance carrier from the clinical or billing office.

This office is not responsible for any disclosure of your confidential medical information once we provide this information, AT YOUR request, to your insurer, employer, family member or otherwise. With this full understanding, I indemnify and hold harmless this practice for any disclosure, which is out of my physicians, his staff and/or his billing office control.
By my signature, I state that I have read, understand, and agree to this Authorization and Release.

_____ _____

Patient Signature Date