DR. ANNETTE LACASSE, D.O. P.C.
8906 Commerce Rd., Suite #5
Commerce Twp., MI 48382
248-363-5555

HIPAA

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

NAME (Print)_____Birthdate_____

Signature_____

Date_____

Authorization to release information to my primary physician: ____yes ____no
Dr. _____
Address:_____
City:_____
Phone:_____

I allow my medical information to be disclosed with:

- ☐ Spouse Name_____
- ☐ Child Name_____
- ☐ Caregiver Name_____
- ☐ Other Name_____
- ☐ Guardian Name_____

IF YOU WISH TO HAVE A FAMILY MEMBER RECEIVE INFORMATION REGARDING YOUR MEDICAL RECORDS, YOU MUST SIGN THE **MEDICAL RELEASE AUTHORIZATION FORM.**

I UNDERSTAND THAT THE OFFICE OF DR. LACASSE MAY BILL THE INSURANCE COMPANY FOR ANY PROCEDURES/SURGERIES RENDERED. I AUTHORIZE THE RELEASE OF ANY M EDICAL INFORMATION NECESSARY TO PROCESS THESE CLAIMS WITHIN THE CALENDER YEAR. I WILL BE RESPONSIBLE FOR ANY UNPAID BALANCES

******SIGNED:_____**