3 Care Lane, Suite 100
Saratoga Springs, NY 12866
ph:/518.871.9900
f:/518.691.0236
richardkimmedicine.com

Patient Name: ____

AMD Chart #: _____________________ Date of Birth: _____________________

MEDICAL RELEASE OF INFORMATION: I hereby authorize Richard Kim Medicine and its representatives to furnish medical information, including photographic or faxed copies of my records to my referring physician(s) and to my insurance company if requested. As patient or legal guardian of patient, I understand that payment for today's services is ultimately my responsibility. I also authorize a representative of Richard Kim Medicine to speak with my insurance carrier on my behalf if required.

I understand that this office bills insurance as a courtesy and that payment of the charges for these services is my responsibility. A photographic copy of this authorization shall be as valid as the original.

Patient Initials: __________

PATIENTS WITH MEDICARE PLEASE READ AND SIGN: I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Patient Initials: __________

COMPENSATION / NO FAULT RELEASE: I do hereby declare that the reason for todays exam is **not** in any way related to a work injury or a motor vehicle accident.

Patient Initials: __________

AUDIO AND VIDEO RECORDING POLICY: I, the patient or patient’s representative, agree to refrain from audio and or video recording of this and any interaction held between, myself as the patient or representative, with Richard Kim Medicine. For the explicit reason of quality, safety, and HIPAA compliance I understand that the nature of recordings, either visual and/or audio, can be manipulated, misconstrued, and misinterpreted. Therefore, I, as the patient or as the patient’s representative, understand that failure to acknowledge and sign to this agreement may result in termination of physician/patient relationship. I am, however, eligible to obtain a copy of the paper medical records, in its entirety.

Patient Initials: __________

My personal health information can be released to:

____

Signature of Patient, Parent or Legal Guardian:

____

Witness: ____

Date of Service: ___________________