Michael Cannon MD
Personalized Medicine

16216 Baxter Road, Suite 340
Chesterfield, MO 63017
Office: 314-325-8925

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name:_____ Date of Birth:_____

I authorize the use of disclosure of the above-named individual's health information as described below.

TYPE OF MEDICAL INFORMATION TO BE DISCLOSED

___ Complete Medical Record	___ Consultation Reports	___ X-ray reports/EKGs
___ Physician Progress Notes	___ Problem list	___ Medication list
___ Immunization Records	___ Lab Reports	___ Other (please specify)_____

___ My health information relating only to the following treatment/condition_____
___ My health information only for the following date_____

INFORMATION TO BE RELEASED **BY:**	INFORMATION TO BE RELEASED **TO:**
Organization/Person Name	Organization/Person Name
Address	Address
City, State, ZIP	City, State, ZIP
Phone	Phone

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It also may include information about behavioral or mental health services, and treatment for alcohol and drug abuse or self-paid services. You are hereby **specifically authorized to release** all information or medical records relating to such diagnosis, testing or treatment, unless specifically excluded below.

I understand I have a right to cancel this authorization at any time. I understand if I wish to withdraw this authorization, I must do so in writing. I must present my written cancellation to the health information management department. I understand the authorization withdrawal will not apply to information that has already been released due to this authorization. I understand the cancellation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise cancelled, this authorization will expire on the following date or event _____. If I fail to specify an expiration date or event, this authorization will expire in six months.

I understand authorizing the release of this health information is voluntary. I can refuse to sign this authorization. I do not have to sign this form to receive treatment. I understand I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand any disclosure of information carries with it the possibility for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact my physician's office manager. I understand there may be a charge associated with copying my health information.

_____ _____
Signature of Patient/Legal Representative Date

Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

I understand that as part of my healthcare, Michael Cannon, MD Personalized Medicine, LLC originates and maintains health records, not limited to, describing my health history, symptoms, examination, test results, diagnoses treatment, and any plans for future care or treatment. I understand that this information is considered protected health information (PHI) and disclosure of the information will be limited to the minimum amount necessary to accomplish that stated purpose. PHI may be used to communicate with other healthcare professionals and/or third-party payers.

I have been provided with the Notice of Privacy Practices that provides a more complete description of protected health information uses and disclosures. I understand that I have the right to review the Notice of Privacy Practices at anytime. I understand that Michael Cannon, MD Personalized Medicine, LLC reserves the right to change its practices and to make new provisions for all PHI maintained by Michael Cannon, MD Personalized Medicine, LLC.

Authorization of release of medical information

May we leave messages on your answering machine? ❍ Home ❍ Cell ❍ Both

May we leave a message at your place of employment to call our office? ❍ Yes ❍ No

May we discuss your medical conditions with members of your family or friends who may contact the office. If you answered "yes", please complete an Authorization for Specific Use and Disclosure for Protected Health Information Form ❍ Yes ❍ No

Please list any information that you would not wish to have disclosed

_____

_____

_____

This release may be rescinded in writing at any time. Michael Cannon, MD Personalized Medicine, LLC cannot guarantee your request will be honored to the fullest. In the event of an emergency, Michael Cannon, MD Personalized Medicine, LLC may disclose information that is related to your emergency condition.

_____ _____

Signature of Patient or Legal Guardian Date

_____ _____

Witness (Michael Cannon, MD Personalized Medicine) Date

MICHAEL CANNON, MD PERSONALIZED MEDICINE, LLC

16216 Baxter Road, Suite 340
Chesterfield, MO 63017

PATIENT INFORMATION

Please complete and/or verify all information and make changes as necessary.

Today's Date:					
Patient Name (First-Middle-Last)		**Date of Birth**	**Age**	**Gender** M F	**Marital Status** M S D W
Home Phone No.	**Cell Phone No.**	**Pt. Social Security No.**	**E-mail Address**		
Address Street #	**City/State/ZIP**	**Employment Status** Employed Unemployed Retired Student			
Name of Employer/School	**Occupation**	**Employer Address (Street-City-State-ZIP)**	**Employer Phone No.**		
Emergency Contact	**Relationship**	**Phone No.**	**Best # To Reach You During the Day** Home Cell Other (Pls. specify)		

GUARANTOR INFORMATION/ INSURANCE INFORMATION

Name of person who is financially responsible for this patient?	**Relation to Patient**	**Phone No.**	**Date of Birth**
Primary Insurance Co.	**Subscriber Name**	**Date of Birth**	**Relationship to Patient**
Secondary Insurance Co.	**Subscriber Name**	**Date of Birth**	**Relationship to Patient**

LEGAL GUARDIAN (IF MINOR)

Legal Guardian Name (First-Middle-Last)	**Address Street #**	**City/State/ZIP**	**Phone No.**

PATIENT DEMOGRAPHICS

CMS is implementing a Health Equity Initiative to better identify possible disparities in access and quality of healthcare based on race and ethnicity on a nation-wide level, we are required to ask the following demographic questions

RACE
- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ African American
- ☐ Caucasian
- ☐ Other
- ☐ I prefer not to report

ETHNICITY
- ☐ Hispanic/Latino
- ☐ Not Hispanic/Latino
- ☐ I prefer not to report

PREFERRED LANGUAGE
- ☐ English
- ☐ Spanish
- ☐ Sign Language
- ☐ Other
- ☐ I prefer not to report

ASSIGNMENT OF BENEFITS & AUTHORIZATION TO RELEASE INFORMATION

I hereby assign payment of authorized Medicare, Medicaid and/or any Insurance Carrier listed to include major medical benefits to which I am entitled, to be made on my behalf to Michael Cannon, MD Personalized Medicine, LLC for any services furnished by that physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents, and/or any Insurance Carrier listed, any information needed to determine these benefits or the release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the CMS 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown.

Patient (Legal Guardian)'s Signature _____ **Patient (Legal Guardian)'s Printed Name** _____ **Date** _____

MEDICARE: Michael Cannon, MD Personalized Medicine, LLC accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

INSURANCE: I understand that I am financially responsible for all charges whether or not paid by said insurance. I also understand that all office co-pays are due at time of service. In addition, I agree to pay any additional charges related to the cost of collection including but not limited to collection agency fees, reasonable attorney fees and court costs, in the event that I would fail to pay my bill.

Guarantor's Signature _____ **Guarantor's Printed Name** _____ **Date** _____