Caring Partner Medical Clinic
Acknowledgement and Authorization Form

_____	_____	_____
Print Name	Date of Birth	Date

- I have read and understand the HIPAA/Privacy Policy for **Caring Partner Medical Clinic PLLC DBA Dr. Francis C. Oramalu**

  Signed _____

- I hereby assign my insurance benefits to be paid directly to the healthcare provider

  Signed _____

- I authorize **Caring Partner Medical Clinic PLLC DBA Dr. Francis Oramalu** to release medical information required to process my claim

  Signed _____

- I have read and understand the Financial Policy for **Caring Partner Medical Clinic PLLC DBA Dr. Francis Oramalu**

  Signed _____

- I authorize **Caring Partner Medical Clinic PLLC DBA Dr. Francis Oramalu to** obtain/have access to my medical history

  Signed _____

- I authorize my provider's office to contact me via
  - ❑ cell phone
  - ❑ home phone
  - ❑ email
  - ❑ all of the above

  Signed _____