C...ldren's Diabetes & Endocrinol...y
9720 Park Plaza Avenue, Suite 202
Louisville, KY 40241
Phone: 502-327-9703

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission or as otherwise permitted by law. If you provide us with permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provide to you.

We appreciate your trust and confidence.

AGREEMENTS, AUTHORIZATIONS, AND CONSENTS

I HEREBY CONSENT AND CERTIFY THE FOLLOWING:

A. **CONSENT TO TREATMENT**: The undersigned grants authority to Dr. Susan Raghavan, and their office staff to perform those procedures and treatments deemed necessary for this patient that are generally used in the care of patients. It is understood that the patient or his/her agent also consent to the performance of special diagnostic studies and/or surgical procedures deemed necessary.

B. **ASSIGNMENT OF BENEFITS**: I assign all rights and privileges and authorize payment directly to Dr. Susan Raghavan and for any claim filed on my behalf for surgical and/or other medical insurance filed now or in the future including disability, no fault, and liability benefits. I agree this assignment is primary to any assignment given after this date including any cost relative to attorney fees.

C. **GUARANTEE OF PAYMENT**: I agree to be responsible to Dr. Susan Raghavan for charges resulting from services rendered. I agree all bills are due in full upon demand. Should I fail to honor this agreement, I agree to pay any collection costs, court costs, or attorney fees resulting from the collection of my accounts. This is a guarantee of payment - not a guarantee of collection.

D. **RELEASE OF INFORMATION**: I authorize Dr. Susan Raghavan, and their office staff to release information from all or part of my medical or financial record to any corporation, person or agency that Dr. Susan Raghavan have good cause to believe is responsible or will be responsible for payment of outstanding charges.

E. **PROCUREMENT OF INFORMATION**: The undersigned designates and authorizes Dr. Susan Raghavan to be his/her agent for the purpose of rendering such consent to other physicians, hospitals, or clinics as may be necessary to obtain from them such previous or current records as needed for the patient's current medical care.

CERTIFICATION: The undersigned certifies that he/she has read the foregoing and that he/she understands the nature and purpose of these consents to his/her satisfaction, and that he/she is the patient or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

ACKNOWLEDGEMENT: I acknowledge that I have received a notice of Privacy Practices.

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Patient Signature Date