Medicaid Signature on File:
I request that payment of authorized Medicaid benefits be made on my behalf to **Pediatric Partners, LLC** for any services furnished to me by the provider. I authorize any holder of medical information about me to release to the Nebraska Department of Health and Human Services (HHS), Center for Medicare and Medicaid Services (CMS) and its agents any information to determine these benefits payable for related services in accordance with current regulations.

Private Insurance Authorization for Assignment of Benefits/Information Release:
I, the undersigned, authorize payment of medical benefits to **Pediatric Partners, LLC** for any services furnished to me by the provider. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

HIPAA Acknowledgement:
I have read the Notice of Privacy Practices or had it explained to me. I understand this Notice and have had the chance to ask questions about any matters I don't understand.

Authorization to Access Rx History Information:
I hereby authorize **Pediatric Partners, LLC**, Inc to access historical prescription drug information. If this authorization is refused, this practice will not be able to prescribe controlled drugs to you.

For Staff Use Only

The following good faith efforts were made to obtain acknowledgement:

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However, acknowledgment was not obtained because:

____

__________________________ ______________
Staff Signature Date

Communication with Family and Friends:
I authorize Pediatric Partners, LLC, to disclose information about my medical conditions and/or treatment to the following people:

Name: __________________________ Relationship: ____________________

Name: __________________________ Relationship: ____________________

Name: __________________________ Relationship: ____________________

The above information is true to the best of my knowledge.

X__________________________________ ______________
Name: DOB: Date

Patient, Parent or Guardian Signature (if child is under 19 years old)