Patient Name:

Date of Birth:

Authorization for Release of Information by Northwell Health

Insurance Companies and Third Party Payer- I hereby authorize and direct Northwell Health, having treated me, to release to governmental agencies, insurance carriers or others who are finically liable for my hospitalization and medical care. All information needed to substantiate payment for such hospitalization and medical care and to permit representatives, thereof to examine and make copies of all records relating to such care and treatment.

Discharge Planning Services- In the event that I require post-hospital services upon my discharge from Northwell Health, I hereby authorize Northwell Health to release medical record information, including my (the patients) medical records, portions thereof or information therefrom (as it deems appropriate), to providers of post-hospital care services, including but not limited to residential health care facilities and home care agencies for the purpose of facilitating necessary discharge planning arrangements.

Patient Valuables- It is understood and agreed that the Hospital cannot accept any responsibility for the loss or damage of articles which the patient or legal representative considers valuable. The hospital has no provisions for the safekeeping of money or other valuables and these should either be kept at home or kept in the safekeeping of family or friends.

I release the Hospital from any and all liability for the loss or damage to any "valuables" which I may choose to retain in my assigned room or any storage area therein, despite the warning and advice in this document.

"Valuables": the term includes, but is not limited to, money, credit cards, personal documents, checks, jewelry, clothing, furs, dentures, eyeglasses, hearing aids and personal items to which the patient may attach unusual value.

Financial Agreement- The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services rendered to the patient, he/she herby obligates him/herself to pay the amount of the hospital, in accordance with the rates and terms of the hospital. Should the account be referred to any attorney for collection, the undersigned shall pay reasonable attorney fees and all collection expenses.

Assignment of Benefits- I hereby assign, transfer and set over to the above named Hospital sufficient monies and/or benefits to which I may be entitled from the government agencies, insurance carriers or others who are finically liable for my hospital medical care and treatment to me or my dependent in said hospital.

Assignment of Benefits for Patients Entitled to Medicare Benefits- I certify that the information given to me in applying for payment under the title XVIII of the Social Security Act is correct. I authorize any holder of the medical or other information about me to release to the Social Security Administration, its intermediaries or carriers, any information needed for this or a related Medicare claim. I request that the payment or authorized benefits be made on my behalf. I assign the benefits payable for physician series to the physician or organization furnishing the services. In addition, I authorize the hospital assignment of my Lifetime Reserve inpatient days should my full Benefit and Co-Insurance inpatient days become exhausted.

The undersigned certifies that he/she has read the forgoing and is the patient or is duly authorized by the patient as the patient's agent to execute the above and accept its terms.

If the patient is a minor, incompetent or unable to sign:

_____
(Patient Signature)

_____
(Person Responsible Signature)

_____
(Witness Signature)

_____
(Relationship to Patient)

_____
(Date)