STUART M. HOMER MD
& ASSOCIATES

HYPERTENSION • NEPHROLOGY • INTERNAL MEDICINE

Release of Records

I, _____ authorize physicians, specialist and facilities who hold my medical records to release to **STUART M. HOMER, MD** at **1030 ST GEORGES AVE, SUITE 201, AVENEL, NJ, 07001** copies of my medical records. I understand this release includes primary care physicians, specialist, medical and diagnostic facilities. I further authorize the release of my insurance carrier and policy numbers to Stuart M. Homer MD and Associates. I recognize that the sharing of this confidential information is necessary to facilitate my medical care.

Signed: _____ **Todays Date:** _____

Date of Birth: _____

Consent for RX Hub Inquiry

I hereby provide my consent for the practice of Stuart M. Homer MD & Associates to obtain my RX history using SureScripts-RxHub network. I understand that this inquiry will provide my physician with the accounting of my medication history reported by Pharmacy Benefit Managers and retail pharmacies. I also understand that SureScripts-RxHub has certified that Rx History Capture follows strict security protocols to align with HIPAA requirements and respect patient privacy. All quires and responses are made automatically through secure system-to-system communications.

Signed: _____ **Todays Date:** _____

Designation of Disclosure and Privacy Practices (HIPAA)

I agree that my Protected Health Information (PHI) may be shared with the following people:

1: _____ **2:** _____

We are required by law to maintain the privacy and security of your protected health information (PHI). We are also required to provide you with our notice of privacy practices which describes our legal responsibilities and your rights regarding the use and disclosure of your PHI. Your signature below is an acknowledgement that you have received our notice of privacy practices. (Please ask for your copy.)

Signed: _____ **Todays Date:** _____

Assignment of Benefits

I authorize; 1. The use of this form, whether original or copy to be used on my insurance and/or Medicare; 2. Release of information to all my insurance companies including; 3. Payment directly to Stuart M Homer MD & Associates from Medicare, all insurance companies, and/or third party payers; 4. MD to act as my agent in helping me obtain payment from my insurance company and/or Medicare. I understand that I am responsible for my bill. I request that payment of authorized Medicare benefits be made on my behalf to MD. I give permission to MD to fill out the Medicare forms on my behalf.

PrintName: _____ **Todays Date:** _____

Signature: _____