ALPINE
MEDICAL GROUP

ACKNOWLEDGEMENT AND AUTHORIZATION:

- **I have read and understand the HIPAA/Privacy Policy for ALPINE MEDICAL GROUP LLC**

Signed____ Date:________________________

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

Signed____ Date:________________________

- **I authorize ALPINE MEDICAL GROUP LLC to release medical information required to process my claim**

Signed____ Date:________________________

- **I have read and understand the Financial Policy for ALPINE MEDICAL GROUP LLC**

Signed____ Date:________________________

- **I authorize ALPINE MEDICAL GROUP LLC to obtain/have access to my medication history**

Signed____ Date:________________________

I authorize my provider's office to contact me by mobile phone

Signed____ Date:________________________

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