Charisse Litchman, MD

In accordance with Federal and State government regulations under HIPPA

Please initial each item.

1. I ________ provide this signature as authorization of payment of all medical service to Charisse Litchman, MD to be received at the following address.

   Charisse Litchman, MD
1250 Summer Street, Suite 202
Stamford, CT 06905

   I understand that non-covered services and services rejected by my insurance carrier will become solely my (patient or guardian) responsibility.
2. I ________ authorize Charisse Litchman, MD to permit the release of medical records to other health care providers, or other information necessary to process claims. I also request payment of government benefits directly to Charisse Litchman, MD, at the above address, for all medical services rendered.
3. I _________ authorize Charisse Litchman, MD, as well as the staff, to contact me regarding results of medical tests or procedures. They MAY_____ or MAY NOT_____leave a message on an answering machine or with persons taking messages at the phone number I provide on my registration form.
4. I _________ authorize the physician, as well as the staff, to contact me to confirm appointments. They MAY_____ or MAY NOT______ leave a message on an answering machine or with persons taking messages at the phone number I provide on my registration form.

I understand that for my protection, prescriptions will not be called into my pharmacy.

5. I_____ authorize the physician as well as the office staff to fax/mail/ email prescriptions to my pharmacy.

AUTHORIZATION TO DISCUSS MEDICAL INFORMATION

I______ authorize Charisse Litchman, MD, to speak about my medical care to the following family members: ____________________________________

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Signature_____________________________**Date**__________________________