2025

Authorization of Prescription Pick Up – Village at Newtown Medical Center

Patient's Name:_____

Patient's Date of Birth:_____

I hereby authorize _____ to pick up the following in the office on my behalf. **Check all that apply**

- Prescriptions
- Test Results
- I understand that I may revoke this authorization at any time by notifying The Village at Newtown Medical Center in writing. If I choose to do so, my revocation will not affect any items taken by The Village at Newtown Medical Center before receiving my revocation.

- I understand that I may refuse to sign this authorization, and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

This authorization expires on: _____

Signature of Patient or Patient's Personal Representative: _____

Date: _____

If Personal Representative:

Name:_____

Signature:_____

Relationship to Patient:_____

Driver's License Number:_____ State:_____

2025

Village at Newtown Medical Center
Consent to Disclose PHI Payment, and Health Care Operations

This form must be completed by the individual whose protected health information is to be disclosed or by a parent or guardian if the person is a minor under state law.

Name:_____

Date of Birth:_____

I hereby authorize Village at Newtown Medical Center to release the following personal health information for: (check all that apply)

- Medical services claims information and test results
- Prescription, diagnostic, treatment, and/or care management services
- Reviews by HHS or HIPAA-compliant health care operations

The above information may be released to:

- Please call (Check one) my home _____ _ my work _____ my cell _____
  Phone Number # _____
  The best time to reach me is: Day _____ Evening_____

- Fax: _____
- Mail: _____
- Friend or Relative:_____

My Consent:

Effective: Today's Date:_____

I want this consent to:

- Continue indefinitely
- Continue only until_____(date)

I understand that consent may be revoked by me at any time. I understand why I have been asked to disclose this information and am aware that my patient rights are identified in the practice's Notice of Privacy Practices.

Signature of Patient:_____Date:_____

Or Personal Representative: _____Date:_____

2025

Village at Newtown Medical Center
Consent to Patient E-mail

At various times the Village at Newtown Medical Center will e-mail patients regarding office hours, appointments, and general health related information.

This Form must be completed by the individual whose e-mail information is to be disclosed or by a parent or guardian if the person is a minor under state law.

Name: _____

Date of Birth: _____

E-mail address: _____

I hereby authorize Village at Newtown Medical Center to e-mail my personal e-mail address various information related to health and or appointments, office hours etc.

My Consent:

Signature of Patient or Patient's Representative: _____

Effective: Today's Date: _____

I want this consent to:

- Continue indefinitely
- Continue only until_____(date)

I understand that consent may be revoked by me at any time. I understand why I have been asked to disclose this information and am aware that my patient rights are identified in the practice's Notice of Privacy Practices.

Signature of Patient: _____Date:_____

Or Personal Representative: _____Date:_____