PINNACLE
HEALTHCARE SYSTEM

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Pembroke Pines, FL 33024
Tel. (954) 963-2151
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RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of **Pinnacle Healthcare System's** Notice of Privacy Practices.
Patient Name

_____ _____
Signature of Patient or Personal Representative — Date

_____ _____
Patient's Name — Name and Relationship of Personal Representative

PATIENT'S SIGNATURE RELEASE AUTHORIZATION AND STATEMENT OF FINANCIAL RESPONSIBILITY

I authorize use of this form on all my insurance submissions. I understand that **I am financially responsible** for the charges not covered by this assignment or for any and all charges which the insurance carrier declines to pay. I authorize payment directly to **Pinnacle Healthcare System**.

_____ _____
Signature of Patient or Personal Representative — Date

_____ _____
Patient's Name — Name and Relationship of Personal Representative

PATIENT'S RELEASE TO VIEW MEDICATION HISTORY

One of the features of electronic prescribing systems is that it allows us to view medications that have been electronically prescribed to you by other physicians. This improves patient safety by helping us avoid prescribing medications that might interfere with what you are already taking. By signing below, you authorize us to view your medication history.

_____ _____
Signature of Patient or Personal Representative — Date

_____ _____
Patient's Name — Name and Relationship of Personal Representative