Please Print

Please Print

345 23rd Avenue N Suite #306
Nashville, TN 37203
(615) 320-3999 Fax: (615) 320-8877

RELEASE OF INFORMATION

(Please write the name/telephone number of any physician *other than Dr Lohrey* that you have seen in the past 3 years. We are able to obtain address and fax if you do not know it. Thank You)

_____/_____/_____
Social Security Number

_____/____/_____
Patients Date of Birth

_____
Last Name

_____
First Name

_____
Middle

Please Read and Sign at the bottom:

I authorize _____ at _____

Telephone # (____)_____-_____, Fax# (____)_____-_____

I authorize _____ at _____

Telephone # (____)_____-_____, Fax# (____)_____-_____

To release my medical information from ____/____/_____ to ____/____/_____ to Pinnacle Medical Group for the purpose of treatment.

* I **authorize** _____ to obtain medical information about me. This person is a relative or friend to whom I trust. If at any point I wish to revoke this authorization I will do so in writing.

* I **authorize** Pinnacle Medical Group to leave messages on my home phone or cell phone. Initial for approval_____

I request that payment of authorized Medicare and other insurance benefits be made on my behalf to Pinnacle Medical Group for any services furnished me by Pinnacle Medical Group.

I **authorize** any holder of medical information about me to release to the Health Care Financing Administration and its agents or my insurance company any information needed to determine benefits payable for related medical services.

I grant permission to view my prescription history from external sources.

I **agree** to be fully responsible for the fees of any services my insurance does not pay (i.e. co-pays, co-insurances, deductibles and any elective services).

I authorize any other physician or health care provider I have seen or any clinic, hospital or other facility to send medical information to Pinnacle Medical Group. I understand that Pinnacle Medical Group may re-release the information and it may no longer be protected by federal privacy regulations. Pinnacle Medical Group will not use, disclose, or receive any compensation for individual patient information for marketing purposes.

I understand that I have the right to refuse to sign this form and the right to a copy of this release. I understand that I have the right to revoke this authorization by submitting a request in writing to the Privacy Officer listed at the above address. Once Pinnacle Medical Group receives this revocation, they will not continue to release medical information, but it is not retroactive.

X_____
Signature of patient (or patient's representative)

_____/_____/_____
Date

* This authorization is to expire one year from the signed date unless otherwise noted.