

**Patient Name:** \_\_\_\_\_

**Read the following release of information. Please sign and date below.**

I have been presented with a copy of Jackson Pulmonary Care, P.A.'s Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

\_\_\_\_\_

Further, I permit a copy of this authorization to be used in place of the original. Regulations pertaining to medical assignment of benefits apply. I agree to and authorize medical treatment as deemed necessary by Jackson Pulmonary Care, P.A. I hereby authorize Jackson Pulmonary Care, P.A. to furnish information concerning my treatment to insurance companies as deemed necessary, and I hereby irrevocably assign to Jackson Pulmonary Care, P.A. all insurance benefits payable to me by my insurance company, not to exceed the charges shown. I understand that I am financially responsible for any amounts that are not covered by my insurance and this authorization. Jackson Pulmonary Care, P.A. cannot accept responsibility for my account. The undersigned further agrees that in the event of his/her account is turned over to an attorney, the undersigned shall be responsible for all costs of collection, including out of pocket expenses, court costs, and attorney fees.

I request that payment of authorized Medicare benefits be made to me or on my behalf to Jackson Pulmonary Care, P.A. for any services furnished me by that clinic. I authorize any holder of medical information about me to release to the Health Care Financing Administration its agents any information needed to determine these benefits or the benefits payable for related services.

**Signed: (Patient or Responsible Party if not signed by patient-state relationship):**

\_\_\_\_\_ **Date:** \_\_\_\_\_

Jackson Pulmonary Care, P.A. may leave a verbal message concerning appointment times at any number provided.

\_\_\_\_\_ I approve                      \_\_\_\_\_ I disapprove

**Authorized Individuals to discuss results: (other than patient)**

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_