MEDICAL RELEASE FORM

Please list below the names, relationship, and phone numbers for any authorized individual, (spouse, family members, friends, caregivers, etc.) that we may discuss your medical or financial information with.

NAME	RELATIONSHIP	PHONE NUMBER

May we leave medical information on "home" answering machine? Circle **YES** or **NO**

Signature of Patient/ Parent Date

OR

If you **DO NOT** want your medical or financial information discussed with anyone other than yourself, please sign here.

Signature of Patient/ Parent Date

The above is private and confidential and will be placed in your medical chart. The information on the form will remain valid until we are notified otherwise.

Acknowledgement of Receipt of Notice of Privacy Practices

(To be filed in patient's medical record)

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

Signed: _____ Date: _____

Relationship (if not signed by patient): _____

I wish to place the following restrictions on disclosure of my health information:

_____

Internal Use Only

If patient/patient's representative refuses to sign acknowledgement, please document date and time notice was presented and sign below.

Presented on (Date and Time): _____

By (name and title) _____

I authorize Montgomery Pulmonary Consultants, P.A. to furnish information to insurance carriers concerning my illness and treatments and I hereby assign the physician(s) all payment for medical services rendered to myself and my dependents.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT COVERED BY INSURANCE.

DATE: _____ SIGNATURE: _____

(For Office Use Only) Initials: _____ Date: _____