

RELEASE OF INFORMATION

I authorize the release of any medical information necessary to process this claim. I also authorize the release of medical information to any physician involved in my care, necessary to ensure continuity of care. I permit a copy of this authorization to be used in place of the original.

Initials: _____

ASSIGNMENT OF BENEFITS

I hereby authorize Pulmonary & Sleep Associates to apply for benefits on my behalf for covered services rendered by any of our providers or by their orders. I request that payment from my insurance company be made directly to Pulmonary & Sleep Associates (or the party who accepts assignment). I certify that the information I have reported with regard to my insurance coverage is correct. I understand that I am financially responsible for charges not covered by this assignment. I permit a copy of this authorization to be used in place of the original. Either my insurance company or I may revoke this authorization at any time in writing.

Initials: _____

AUTHORIZATION FOR COMMUNICATION

I hereby authorize Pulmonary & Sleep Associates to communicate in person, or by message, through the phone number(s) and address(es) I have provided. I understand that simple information such as appointment reminders may be left on my answering machine, but that detailed information regarding my health or financial status will only be communicated in person. I understand that I may limit this communication at any time, by providing a written request.

Initials: _____

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

I hereby acknowledge that I have reviewed a copy of Pulmonary & Sleep Associates' Privacy Policy Notice. I understand that I may request a copy of it at any time.

Initials: _____

CONSENT FOR RESEARCH

I understand that I may be contacted regarding voluntary participation in research, at the discretion of my provider. I further understand that I may decline participation at any time, without negative consequences. I am giving my consent for initial contact unless my refusal is documented here _____.

initials

Initials: _____

Signature of patient or legal guardian: _____

Date: _____