Lexington Clinic

PATIENT PRIVACY AUTHORIZATIONS

**These authorizations do not cover the release of written medical records.*

AUTHORIZATION FOR RELEASE OF PATIENT ACCOUNT INFORMATION*

If you wish to appoint an individual or individuals to discuss your account information, you must complete and sign a **Release of Account Information** form (below). This form provides Lexington Clinic permission to discuss your account information, in a secure method, with the person or persons you have designated. To complete the form, please follow the steps listed below.

1. Complete the patient information, including social security number
2. Provide the full name and last 4 digits of the social security number of the person or persons who will be allowed access to your account information.
3. Sign and date the form.
4. Return the completed form to Lexington Clinic Registration or mail it back using the enclosed envelope.
5. The form will be valid until a verbal or written request for cancellation is provided to the Lexington Clinic Business Office.

Patient Name _____
Last *First* *Middle Initial*

Date of Birth _____ SSN _____ Lexington Clinic # _____

Address _____

Phone _____
Home *Work* *Cell*

I hereby give my permission for Lexington Clinic to discuss any and all information on my account, including but not limited to, my medical services and payment records for the purposes of account review and inquiry with the following person:

Name_____ SSN_____
Last 4 digits

AUTHORIZATION FOR VERBAL COMMUNICATION / PERMISSION TO COMMUNICATE*

May we leave information regarding your diagnosis, treatment, and follow-up on your home answering machine?
_____ Yes _____ No Patient must provide number: _____

We may discuss your diagnosis, treatment, and follow-up with the family member(s) and/or caregiver(s) listed below:
(Please print)

Name:	Phone:
Name:	Phone:
Name:	Phone:
Name:	Phone:

I understand this form will be valid until a verbal or written request for cancellation is provided directly to the Lexington Clinic Business Office.

*Patient Signature*_____ *Date*_____