Penn-Tampa Neurology

Thomas 0. Pearson, MD - Certified by the American Board of Neurology

Authorization for Release of Medical Information

Patient Name: _____ DOB: _____

Today's Date: _____ SS#: _____

I authorize Dr. Pearson to *release* my information in my record to any medical practitioner, physician, hospital, medical institution or facility to which I may be referred to assist in my care.

I authorize Dr. Pearson to *obtain* any information any medical practitioner, physician, hospital, medical institution or facility to which I may be referred to assist in my care.

Family & Friends

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

PPO / HMO Patients Financial Responsibility

I understand that I am insured through an HMO /PPO Ian. I understand that it is my responsibility to obtain the proper and necessary referrals from my primary care physician before seeing Dr. Pearson.

Although Dr. Pearson and his staff will make all reasonable efforts to assure that ordered testing is covered by my medical plan, I also understand that it is ultimately my responsibility to do so before having any testing or treatment.

I understand that I am fully and totally responsible for any fees rejected by my insurance carrier. I shall also be responsible for any appeals of such rejected claims.

I further agree to inform Dr. Pearson's office of any changes in my insurance coverage for carrier in a timely fashion.

I give permission for Dr. Pearson or his staff to leave a message on voicemail.

Patient Signature: _____