Nashville Vascular and Vein Institute, PLLC
330 23rd Avenue North, Suite 100
Nashville, TN 37203
(615) 321-6100 FAX (877) 663-4069

PATIENT AUTHORIZATION FORM

Name: _____ DOB: _____ Sex: ___M ____F

Race: ___American Indian/Alaska Native ___Black/African American ___Hispanic/Latino

___Native Hawaiian/Other Islander ___White/Caucasian ___Asian ___Other

Social Sec # _____Marital Status: Single___ Married___ Divorced___ Widowed___

Primary Address_____

City: _____ State_____ Zip _____

Home Phone _____ Work Phone _____Cell Phone _____

Referring Doctor: _____ Primary Care Physician _____

Employment Status: Employed___ Not Employed___ Retired___ Student___ Employer:_____

Emergency Contact_____Relationship_____Phone_____

E-mail_____ Authorize E-mail? Yes____ or No_____

Primary Insurance _____ Insurance ID _____

Secondary Insurance _____ Insurance ID _____

Because of the changes made by Congress, we are required to have your explicit permission about how your medical information is handled. You may request a copy of the Notice of Privacy Practices (NOPP) from our staff. A copy of our Financial Policy is also available for you upon request. Please read each authorization carefully and indicate your approval by initialing in the box provided.

	Patient Initials
I authorize the release of all medical records maintained by Nashville Vascular and Vein Institute, PLLC, which relates to services I have received from, or the results of tests ordered by, Nashville Vascular and Vein Institute, PLLC. These records may be released as needed for my care for the processing of insurance claims, to satisfy the requirements of a managed care organization of which I am a member, and/or to my attorney regarding pending or anticipated litigation under a worker's compensation, motor vehicle accident, and/or third-party liability claim.	
I am giving permission for Nashville Vascular and Vein Institute to obtain my prior films, scans, labs, and any records including demographic, pharmacy and medication history that may identify me and which relates to my past, present, and/or future physical or mental health or condition and related health care services. I understand that it is my responsibility to obtain previous studies, if asked to do so. If it is necessary for an employee of Nashville Vascular and Vein Institute to obtain my prior films, labs, and/or other records, I am giving my permission to call and/or fax on my behalf in order to obtain needed medical records and films.	

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I authorize direct payment of benefits from my insurance plan to Nashville Vascular and Vein Institute, PLLC. I understand that I am responsible for payment of professional fees charged by Nashville Vascular and Vein Institute, PLLC that are not covered or not properly reimbursed under the terms of my insurance plan. Note: Nashville Vascular and Vein Institute, PLLC, will file your insurance or collect self-pay accounts. You, the patient, will be responsible for any personal balance. Any account turned to an outside collection agency will accrue additional fees on the unpaid balance including any attorney or court costs in collecting that balance.	
I will provide Nashville Vascular and Vein Institute, PLLC, with the phone numbers I authorize to be used to contact me. I authorize the use of any messaging person or system, voicemail and/or answering machine to convey information regarding my care. Contact via e-mail is authorized where I have provided my e-mail address to Nashville Vascular and Vein Institute, PLLC.	
I authorize the use of fax or e-mail to send my information to myself or other parties that have a right to receive my information. I understand that every effort is made to protect my privacy; however, no absolute privacy guarantee is given when faxes or e-mails are used.	
I understand that it is my right to request limited access to my records and to withdraw permission for the release of my records. I understand that this request must be in writing and that limiting or withdrawing my permission may result in Nashville Vascular and Vein Institute, PLLC discontinuing its relationship with me. In that case, I will need to seek care from another source.	
I have been offered a copy of the Nashville Vascular and Vein Institute's Notice of Privacy Practices and Financial Policy for my own records.	

In signing this document, I also give my permission and consent for any and all medical information maintained in or generated by the Nashville Vascular and Vein Institute on my behalf to be released to and/or discussed with the following person(s):

Friend or Family Member's Name	Relationship

Signed by the Patient		**Date**	
Print Name			