

Gynecologic Oncology of Middle Tennessee

Please Read and Sign at the Bottom

I **authorize** GOMT to communicate with the below list of family members and friends regarding my medical condition.

List family members whom you give permission to discuss you health status with our office.

List any family member you do **NOT** want us to discuss your health status.

List any close personal friends you give us permission to discuss your health status.

I **authorize** GOMT to leave messages on my answering machine. Yes or No

I **authorize** any other physician or health care provider I have seen or any clinic, hospital or other facility to send medical information to GOMT at 2021 Church Street Suite 402, Nashville, TN 37203 fax (615) 340-4642 telephone (615) 340-4640

I **request** payment of authorized Medicare and other insurance benefits be made on my behalf to GOMT for any services furnished me by GOMT.

I **authorize** any holder of my medical information to release it to the Healthcare Financing Administration and its agents or my insurance company needed to determine benefits payable for related medical services.

I **agree** to be fully responsible for any services my insurance does not pay or does not process in a timely manner, customarily in 60 days.

I **have been offered** the Notice of Privacy by GOMT office personnel.

_____ Date _____
Signature of patient (or patient's representative)