Lexington Clinic
Since 1920

1221 South Broadway
Lexington, KY 40504

100 North Eagle Creek Drive
Lexington, KY 40509

Business Office: 859.258.6000

Patient Instructions for Authorization for Release of 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. This form provides Lexington Clinic with 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 demographic information, including your social security number.

2. Provide the full name and last 4 digits of the social security number of the person 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 Patient Service Department.

5. The form will be valid for one year unless a verbal or written request for cancellation is provided to the Lexington Clinic Business Office.

****Note: This authorization does not cover the release of written medical records.**

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AUTHORIZATION FOR RELEASE OF PATIENT ACCOUNT INFORMATION

Patient Name: _____
Last First Middle Initial

Patient Date of Birth: _____ Patient Phone Number: _____

Patient Address: _____

Patient Social Security Number: _____

Lexington Clinic Patient Account Number: _____

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:

_____
(Please print full name clearly)

To allow secure verification of this person upon each inquiry, please provide the last four digits of his/her Social Security Number: _____

I understand that this authorization is valid for no more than one year and may be cancelled at any time upon my verbal or written request made directly to the Lexington Clinic Business Office.

_____
Patient Signature Date

****NOTE: This authorization does not cover the release of written medical records.**