MidState
PULMONARY

Breathe. Sleep. Heal.

INFORMATION RELEASE

Patient Name: _____ DOB: _____

1. Drs. Tyson, Peacock, Carpenter, Capizzi, Pritchett, Atwater, Phillips, Ferrell and/or a member of their office staff may release medical information to a specified person other than myself. ☐ Yes ☐ No
   If yes, please list authorized persons and their relationship to you below.

Authorized Person	**Relationship**
_____	_____
_____	_____
_____	_____

   Only the persons listed above will be allowed to receive your medical information.

2. What medical information can be released?

Laboratory Results	☐ Yes	☐ No
X-ray Results	☐ Yes	☐ No
Medications	☐ Yes	☐ No
Medical Status	☐ Yes	☐ No
Appointment dates/times	☐ Yes	☐ No

3. If we need to contact you regarding your appointment and we get your answering machine may we leave a message on your machine? ☐ Yes ☐ No
   If someone else answers the phone, may we leave a message? ☐ Yes ☐ No

   May we call you on your cell phone? ☐ Yes ☐ No Cell phone # _____

4. What is the best phone number for us to call with test results? Phone # _____

5. If unable to reach you by phone, may we mail your results? ☐ Yes ☐ No
   If yes, to what address do you want us to send the results?

   _____

Patient Signature: _____ Date: _____

Relationship to Patient: _____

Revised 11.19.2021

PEACOCK ▪ CARPENTER ▪ CAPIZZI ▪ TYSON ▪ PRITCHETT ▪ ATWATER ▪ PHILLIPS ▪ FERRELL
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