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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(Important: All sections **MUST** be completed.)

Patient: _____ Birth Date: _____

Address: _____ Phone: () _____

_____ SS#: _____

RELEASE FROM: _____ Release To: _____

Specific type of information to be released: any/all records Diagnostic reports Lab results

Chart noted Consultation noted Operative notes Other _____

for date range: _____ to _____

(if no time period specified, record from previous 5 years only will be released)

Purpose of disclosure: Transfer of Care – Reason: _____

Disability Worker’s Comp Social Security Insurance

Attorney Request Other: _____

I understand that my medial records may contain information **related to communicable diseases and infection information** as defined by statute and **Tennessee Department of Public Health Rules** (which include venereal disease “VD”, tuberculosis “TB”, Hepatitis (any form), Human Immunodeficiency Virus “HIV”, Acquired Immunodeficiency Syndrome “AIDS” and AIDS Related Complex “ARC”; **Alcohol and/or drug abuse treatment information** protected under regulations in 42 Code of Federal Regulations, Part 2; and **Mental Health treatment records, Psychological services** and/or **Social Services** information including communications made to or by a social worker, psychologist or psychiatrist.

I understand I have to right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the Privacy Officer. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire after one (1) year.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-discloser and the information may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization. If I have questions about disclosure of my health information, I can contact the Privacy Office at the disclosure location.

Signature of Patient or Legal Representative

Date

If signed by Legal Representative, relationship to Patient