Authorization for Release of Medical Information

Section A: Must be completed for all authorizations

I Hereby authorize the use or disclosure of my health information as described below.

Patient Name: _____ **Birth Date:** _____

Persons/Organizations providing the information:

_____

_____

_____

Persons/Organizations receiving the information

Childrens Medical Group
3786 Central Pike, Suite 130
Hermitage, TN 37076
615-883-2200 • Fax: 615-883-1104

Specific description of information:

_____ **Records from this office only**

_____ **Only a portion of the Record (specify)** _____

_____ **Exclude any information pertaining to the listed diagnosis** _____

_____

_____ **If nothing above is checked, the complete medical record will be sent.**

What is the purpose of the use or disclosure?

_____ **At the request of the Individual** _____ **Changing Physicians**

_____ **Moving** _____ **Physician / Staff Request**

_____ **Other:** _____

Section B: Must be completed only if the healthcare provider has requested the authorization

1. The provider must complete the following statement:
   a. Will the healthcare provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? Yes _____ No _____

2. The patient must read and initial the following statement:
   a. I understand that I get a copy of this form after I sign it. Pt. Initials: _____

Section C: Must be completed for all authorizations

I understand that I have the right to refuse to sign this form and that my refusal will not result in the physican conditioning the provision of Healthcare with two exceptions: 1. Refusal to sign this authorization, if it is for disclosure of information created for research the includes treatment, may result in the physican declining to provide the research-related treatment. 2. Refusal to sign this authorization, if it is for disclosure of information created for the sole purpose of disclosure to a third party, may result in the doctor declining to provide the healthcare which is for the sole purpose of creating protected health information for disclosure to a third party Pt. Initials: _____

I understand that this authorization will expire ONE YEAR AFTER DATE OF SIGNED RELEASE

I understand that I may revoke this authorization at any time by notifying the healthcare provider in writing. The revocation will only be effective from the date it is received in this office and will not apply retroactively. Pt. Initials: _____

_____ _____

Signature of patient or patient's representative **Date**

(Pertinent sections of the Form MUST be completed before signing.)

Printed name of patient's representative: _____

Relationship to the patient: _____