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Board Certified Family Nurse Practitioner

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

SECTION A: REQUIRED FOR ALL AUTHORIZATIONS FOR RELEASE OF PHI OR RIGHT TO ACCESS

Patient Name:	**Date of Birth:**	**Social Security Number *(Optional)*:**
Patient's Address/City/State/Zip:		**Patient's Phone:**

I AUTHORIZE:	**PHI Sender Name:** Scenic City Family Practice	**TO:** ✘ Obtain From	**PHI Recipient Name(s):** _____
	Address/City/State/Zip: 1042 Graysville Rd, Ste 2 Chattanooga, TN 37421-4389	✘ Disclose To	_____
	Phone: (423) 661-3600		_____
	Fax: (423) 661-3602		_____
			_____
			_____
			_____

✘ **The authorization will remain fully effective until it is revoked in writing.** _____ **(Initial)**

Purpose of Disclosure:
Transfer/Continuation of care.

Is this request for psychotherapy notes?
❑ Yes, then this is the only item you may request on this authorization. ❑ No, then you may check as many items below as you need.

Description:	**Date(s):**	**Description:**	**Date(s):**	**Description:**	**Date(s):**
❑ **All PHI/Medical Records**	❑ **All Dates**	❑ Physician Orders		❑ Demographics	
❑ History and Physical		❑ Laboratory		❑ Rehabilitation Services	
❑ Consult Report		❑ Imaging/Radiology		❑ Special Test/Therapy	
❑ Operative Report		❑ Nursing Notes		❑ Itemized Bill/Claims	
❑ Progress Notes		❑ Medication Record		❑ Other:	

_____ **(Initial)** I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. If not, applicable, check here ❑

I understand that:

1. I may refuse to sign this authorization and my treatment will not be conditioned upon signature of this authorization (except for non-health related services such as pre-employment testing, life insurance exams, or drug screenings).
2. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
3. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
4. I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
5. I will receive a copy of this form after I sign it.

SECTION B: SIGNATURES

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Guardian/Patient Representative:	**Date:**
✘	
Print Name of Signature of Patient's Representative:	**Relationship to Patient:**