Allergy & ENT Associates of Middle Tennessee, P.C
EST. 1973

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Adult and Pediatric Diseases of the Ear, Nose, and Throat • Head & Neck Surgery
Allergy Testing and Treatment • Hearing and Balance Disorders

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(All sections must be completed)

I hereby authorize Allergy & ENT Associates of Middle Tennessee, P.C. and its physicians, employees, and agents to release or disclose to the below-named recipient all of my medical records including any specially protected records.

Patient Name: _____DOB:_____MRN:_____

I hereby authorize the release of medical records to: _____

_____

Purpose of disclosure: _____

"At the request of the individual" is sufficient when the patient initiates the authorization and elects not to provide a statement of purpose.

This request and authorization applies to:

❏ All medical records

❏ Health care information relating to the following treatment, condition or dates of treatment:

_____

❏ Specific records to be released (eg. Labs, imaging reports, other):

_____

If you DO NOT WANT certain portions of your medical records released, please initial the box for the information you do not want released.

_____Substance abuse _____ Psychological or psychiatric treatment ____HIV/AIDS/STD

The authorization will expire on: _____

Date or Event may not exceed one year

I understand I have a right to revoke this authorization by written notification to the Privacy Officer, except to the extent it has acted in reliance thereon before notice of revocation. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure which may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization.

I understand that under most circumstances a healthcare provider may not condition treatment, payment, enrollment or eligibility for benefits on my signing this authorization. However, I understand that signing an authorization that permits the use and/or disclosure of my protected health information for research purposes may be a condition of my treatment if I am undergoing research related treatment. Also, I may be required to sign an authorization if my treatment is provided solely for the purpose of creating protected health information for disclosure to a third party. And under some circumstances, a health plan may condition my enrollment in a health plan or my eligibility for benefits on my providing an authorization permitting the health plan to make enrollment and eligibility determinations.

I have had the chance to read and think about the content of this authorization form and agree with all statements made in this authorization. I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of the protected health information noted in this form with the people and/or organizations named in this form.

_____

Signature of Patient or Authorized Representative Date Signed

_____Relationship to Patient