

NASHVILLE MEDICAL GROUP

Authorization for Use or Disclosure of Protected Health Information

Patient Name: _____ Social Security Number: _____

Date of Birth: _____ Phone Number: _____

1. I authorize _____ to release my health information to: _____

Use my health information as described below; and/or

Disclose my health information to the following individual or organization:

Address: _____

2. The purpose(s) for the use or disclosure is as follows: _____

3. The type and amount of information to be used or disclosed is as follows:

Health information covering treatment from

_____, _____ to _____, _____
Date of Service Date of Service

Copy of Complete Record

Discharge Summary (DS)

Abstract

Operative / Procedure Report (OP)

(Includes H&P, Progress notes, Procedure reports, Consult, DS, Diagnostic Testing, and all dictated reports.)

Pathology Report

History and Physical (H&P)

Laboratory Report

Consultation

X-Ray Report

Other: _____

4. I understand that my health information may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for drug and alcohol abuse.

5. I understand that I have a right to revoke this authorization at any time. I understand that, if I revoke this authorization, I must do so in writing and present my written revocation to the Director of Operations. I understand that my revocation will not apply to the extent that Nashville Medical Group has taken in reliance on this authorization. I understand that my revocation will not apply if this authorization was obtained as a condition of obtaining insurance coverage and the law provides my insurer with the right to contest a claim under my policy or the policy itself. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire in six months.

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. Nashville Medical Group may not condition treatment, payment, enrollment in its health plan, or eligibility for benefits on my signing this authorization. I understand that if I authorize Nashville Medical Group to disclose my health information, the health information may be subject to redisclosure by the recipient and may no longer be protected by certain federal privacy regulations. If I have questions about disclosure of my health information, I can contact the Director of Operations at 615-284-1400.

Signature of Patient or Legal Representative

Date

If Signed by Legal Representative, Relationship to Patient

ALL BLANKS MUST BE COMPLETED