

Crossville Medical Group, P A

Authorization for Release of Information

PATIENT NAME:
DATE OF BIRTH: LAST - - SS#: - - FIRST MI MAIDEN OR OTHER NAME
ADDRESS: CITY: STATE: ZIP:
DAY PHONE: EVENING PHONE:

I hereby authorize Crossville Medical Group, PA to release information from my medical record as indicated below to:

NAME:
ADDRESS: CITY: STATE: ZIP:
PHONE: FAX:

INFORMATION TO BE RELEASED:

- History and physical exam
Progress notes
Lab reports
X-ray reports
Other:

DATES:

I specifically authorize the release of information relating to:
Substance abuse (including alcohol/drug abuse)
Mental health (including psychotherapy notes)
HIV related information (AIDS related testing)
X
SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

PURPOSE OF DISCLOSURE: Changing physicians
Legal School
Other (please specify):
Consultation/second opinion
Insurance
Continuing care
Workers Compensation

- 1. I understand that this authorization will expire on (Print the # days until this Form Expires, if it does) days after I have signed the form.
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.
4. I understand that if I am being requested to release this information by Crossville Medical Group, PA for the purpose of:
a. By authorizing this release of information, my health care and payment for my health care will not be affected if I do not sign this form.
b. I understand I may see and copy the information described on this form if I ask for it, and that I will get a copy of this form after I sign it.
c. I have been informed that Crossville Medical Group, PA will/ will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.
5. I understand that in compliance with Tennessee statute, I will pay a fee of \$ (Print the Fee Charged). There is no charge for medical records if copies are sent to facilities for ongoing care or follow up treatment.

SIGNATURE OF PATIENT DATE OR PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON DATE
RECORDS RECEIVED BY DATE RELATIONSHIP TO PATIENT

FOR OFFICE USE ONLY
DATE REQUEST FILLED: BY:
IDENTIFICATION PRESENTED: FEE COLLECTED: \$