AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION **FROM** ANOTHER FACILITY

PATIENT NAME:	**Birth Date:**	**SS No. (optional)**
	Other Names Known By:	

Person/Organization Authorized to Disclose Protected Health Information:

Release Records To: The Cardiovascular clinic of west TN	**Address: 162 Murray Guard Dr**	**City: Jackson**	
Attention: ______________________	**Telephone #: 731-256-1819** **Fax #: 731-664-4330**	**State: TN**	**Zip: 38305**

Purpose of Disclosure: ☐ **Medical Care** ☐ **Insurance** ☐ **At the Request of the Patient**
☐ **Media, Public Relations, Marketing, Advertising, Posting, or Radio Broadcasting**
☐ **Other, Please Explain:**

Description of Information to be Used or Disclosed:

Dates of Treatment:	Place of Treatment:

Choose From the Following:

☐ All Dictated Reports	☐ Lab (may include AIDS/HIV information)		☐ History & Physical
☐ Radiology Reports	☐ Pertinent Summary	☐ Discharge Summary	☐ Pathology Reports
☐ ER Record	☐ Consultation	☐ Anesthesia Record	☐ Billing Record
☐ Operative/Procedure Report	☐ Entire Chart	☐ Photographs/Images	☐ Other (specify):

I understand that:

1. **I may revoke this authorization in writing at any time by notifying in writing the person/organization providing or disclosing the information. However, if I revoke this authorization, it will not have any effect on any actions taken by the person/organization providing, disclosing, or receiving the information prior to receiving the revocation, nor shall it be valid to the extent that the disclosing person/organization or receiving organization has taken action in reliance on this authorization.**
2. This authorization allows **The Cardiovascular clinic of west TN** to obtain any and all documents in my medical record including those copies from other health care facilities and providers. I understand that the information that is released or provided may be re-disclosed and no longer protected by federal privacy regulations.
3. Any disclosure of records concerning diagnosis and/or treatment of alcohol and/or drug abuse is covered by Title 42 CFR, and if there is any such information, I hereby authorize the release of information. This authorization also includes any information related to diagnosis and/or treatment of any psychiatric or mental illness or any state of infection with the HIV (AIDS) virus.
4. **The Cardiovascular clinic of west TN** is hereby released from any liability and the undersigned will hold **The Cardiovascular clinic of west TN** harmless for requesting or seeking my protected health information.
5. I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal will affect my ability to obtain treatment, receive payment, or eligibility for benefits.
6. The authorization will expire in ninety (90) days unless I provide an alternate date or event. This authorization will not apply to any dates of service that occur after the date this authorization is signed.
7. A facsimile of this authorization or a copy of this authorization shall be valid and binding with the same force as an original signature, and the person/organization releasing the information shall be entitled to rely on the same.

I have read and understood this authorization. I hereby authorize the release of the above-requested medical information about me to **The Cardiovascular clinic of west TN** from the facility named above.

______________________________ ______________________________
Signature of Patient **Signature of Patient's Authorized Representative**

______________________ __________ ______________________________
Telephone Number **Date** **Description of Representative's Authority to Act for Patient**

8/01
Reviewed 3/04
Revised 6/04