MEDICAL RELEASE AUTHORIZATION

(Allows your physician/provider/nurse or staff to discuss your care or items selected with appointed individuals below).

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

INFORMATION BEING RELEASED BY: **West Tennessee Medical Group Clinic**

Release Information To:	Address (City, State, Zip)	Telephone:	Date of Birth:	Relationship:

Purpose of Disclosure: ☐ Medical Care ☐ Insurance ☐ At the Request of the Patient ☐ Patient Portal ☐ Other, Please Explain:

DESCRIPTION OF INFORMATION TO BE USED OR DISCLOSED:

Dates of Treatment:	**Place of Treatment:** ☐ Inpatient ☐ Emergency Room ☐ Outpatient ☐ Clinic ☐ Other (specify):

Choose From the Following (please initial beside documents or information that may be released):

_____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):

_____ May speak freely with my Physician/Nurse/Provider/Clinic staff regarding all aspects of my care.

I understand that:

1. I may revoke this authorization in writing at any time, but if I do so, it will not have any effect on any actions taken by the facility releasing the information (hereafter referred to as "the facility") prior to the facility's receiving the revocation. Further details regarding the manner in which this authorization may be revoked may be found in the facility's Notice of Privacy Practices.
2. This authorization allows the facility to release the above indicated documents in my medical record, including those copies from other health care facilities and providers as requested. The released information may no longer be protected by federal privacy regulations and may be redisclosed.
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 facility is hereby released from any liability and the undersigned will hold the facility harmless for complying with this authorization.
5. The facility will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization, except for research related purposes and as otherwise permitted under applicable law.
6. The authorization will expire in ninety (90) days unless I provide an alternate expiration date or event. This authorization will not apply to any dates of service that occur after the date this authorization is signed.
7. If the facility will use or disclose my protected health information for marketing purposes, the facility will not receive remuneration or compensation for such use or disclosure for marketing purposes unless the WTH Privacy Coordinator completes and signs the following statement:

I, _____ (signature of WTH Privacy Coordinator) hereby certify that the facility will receive remuneration or compensation for the use or disclosure of this patient's protected health information from _____ (fill in source of remuneration or compensation).

I have read and understood this authorization. I hereby authorize the release, use, and disclosure of the above-requested protected health information about me.

_____ **Signature of Patient**

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

_____ **Date**

Telephone # _____

_____ **Description of Representative's Authority to Act for Patient**