Pediatric Associates of West Tennessee, PLLC

AUTHORIZATION FOR RELEASE OF INFORMATION

Section A: Must be completed for all authorizations

I hereby authorize the use or disclosure of my health information as described below. I understand the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.

Patient Name:_____ **DOB:**_____

Person/Organization providing the information:

_____

_____

_____

_____

Persons/Organizations receiving the information:

Pediatric Associates of West Tennessee, PLLC

_____

_____

_____

Specific description of information including dates: ALL MEDICAL RECORDS

_____

_____

_____

_____

What is the purpose of the use or disclosure: CONTINUITY OF CARE

_____

_____

(Note: "at the request of the individual" is a sufficient description of the purpose when the patient initiates the authorization and elects not to provide a statement of purpose.)

Section B: Must be completed only if the healthcare provider has requested the authorization

1. The provider must complete the following statement:
   a. Will the healthcare provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? Yes _____ No_____
2. The patient must read and initial the following statement:
   a. I understand that I get a copy of this form after I sign it. Patient initials:_____

I understand that I have the right to refuse to sign this form and that my refusal will not result in the provider conditioning the provision of Healthcare with two exceptions: 1. Refusal to sign this authorization, if it is for disclosure of information created for research that includes treatment, may result in the provider declining to provide the research-related treatment. 2. Refusal to sign this authorization, if it is for disclosure of information created for the sole purpose of disclosure to a third party, may result in the provider declining to provide the healthcare which is for the sole purpose of creating protected health information for disclosure to a third party. Patient Initials: _____

I understand that this authorization will expire in three hundred sixty-five (365) 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. Patient Initials: _____

I understand that I may revoke this authorization at any time by notifying the healthcare provider in writing. The revocation will only be effective from the date it is received in this office and will not apply retroactively. Patient Initials:_____

_____ _____

Signature of Patient or Patient's Representative **Date**

(Pertinent sections of the Form MUST be completed before signing)

Printed name of patient's representative:_____

Relationship to patient:_____

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