AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name _____ Chart Number _____

Address _____

D.O.B _____ Phone Number _____ SS Number (Optional) _____

I authorize the use or disclosure of the above named individual's health information as described below:

1. Tennessee Valley Neurological Associates is authorized to make the disclosure.

2. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

- ☐ All /Entire Record
- ☐ Visit/Encounter Notes
- ☐ Laboratory Results
- ☐ X-Ray and Imaging Reports
- ☐ Problem list
- ☐ Medication List
- ☐ Allergies List
- ☐ EKG Report
- ☐ Pathology Report
- ☐ Consultation Report
- ☐ Operative Report
- ☐ Immunization Record
- ☐ Drug and Alcohol Treatment
- ☐ HIV/AIDS/STD Treatment
- ☐ Registration Record
- ☐ Other _____

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

4. Please list the name(s) of any person you wish for TVNA to be able to speak with on your behalf. A person must be listed on this form to speak with the office.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

6. 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 Medical Record Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

7. Unless otherwise revoked, the authorization will expire in **one calendar year.** If you wish for this authorization to expire on a certain date, or if you wish for this authorization to have no expiration, please indicate on the line below.

_____

8. I understand that once the information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal privacy regulations.

9. I understand that I need not sign this form in order to ensure health care treatment, payment, enrollment in my health plan, or eligibility for benefits.

_____ _____ _____

SIGNATURE DATE TIME

_____ _____ _____ _____

IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT SIGNATURE OF WITNESS DATE TIME