Family Health Center

OF ASHLAND CITY PLLC

Rural Health Clinic

342 Frey Street, Ashland City, TN 37015 * 615-792-1199 * Fax: 615-792-9331

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 redisclosure by the recipient and no longer protected by federal privacy regulations.

Patient Name: _____ **Date of Birth:** _____

Persons/organizations providing the information:

_____
_____
_____
_____

Receiving organization:

Family Health Center of Ashland City PLLC
342 Frey Street
Ashland City, TN 37015
FAX# (615)792-9331

Specific description of information (including date(s)): _____
_____

Purpose of the use or disclosure: _____

(Note: "At the request of the individual" is sufficient.)

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

1. The provider must complete the following statement: 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: I understand that I may have a copy of this form after I sign it. Pt. Initials: _____

Section C. Must be completed for all authorizations

I understand that I have the right to refuse to sign this form and my refusal will not result in the physician 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 physician 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 doctor declining to provide the healthcare which is for the sole purpose of creating protected health information for disclosure to a third party. Pt. Initials: _____

I understand that this authorization will expire on the following date ____/____/_____ or with the following event:_____

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. Pt. initials: _____

_____ _____

Signature of patient or patient's representative **Date**

Printed name of patient's representative: _____

Relationship to patient: _____