RELEASE OF INFORMATION

I hereby authorize the release, use, and/or disclosure of my medical records as listed below. I understand that the information enclosed in my records may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.

Patient's Name: _____Social Security #:_____

Address: _____

Birth Date: ___/____/_____

I authorize West Tennessee Hearing and Speech to:

____ **Release my medical records to:** _____
Name and Phone Number

____ **Request/obtain my medical records from:** _____
Name and Phone Number

Purpose of request/uses: ____ Patient Request ____ Continuation of Care ____ Other: _____

Information to be obtained, used, and/or disclosed:

____ Office Records ____ Audiograms ____ Speech/Language Evaluation

____ Speech Therapy Notes ____ Entire Chart ____ Other_____

I understand that the release if my personal medical records may include information concerning my diagnosis and/or treatment for any of the following drug/alcohol abuse, psychiatric or mental illness, sexually transmitted diseases which include Human Immunodeficiency Virus (HIV) and/or AIDS virus. This authorization will expire 12 months (1 year) from the date provided at the end of this form. I understand that I have the right to refuse to sign this authorization and that my refusal will not result in the physician conditioning the provision of Healthcare with 2 exceptions: 1. Refusal to sign this form, if it is for disclosure of information created for research that includes treatment, may result in the center declining to provide the research related treatment. 2. Refusal to sign this form, if it is for disclosure of information created for the sole purpose of disclosure to a third party, may result in the center declining to provide the healthcare which is for the sole purpose of creating protected health information for disclosure to a third party. I understand that I may revoke this authorization at any time by notifying the center in writing. The revocation will only be effective from that date received and it will not apply retroactively. I understand that this authorization will expire one year from the signature date.

_____ _____ _____

Patient or Responsible Parties Signature | Patients Printed Name | Date

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