HMG

AUTHORIZATION FOR RELEASE OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

Holston Medical Group, PC is dedicated to maintaining the privacy of your protected health information (PHI), which is your individually identifiable health information (this includes such data as your name, address, phone number, date of birth, Social Security Number, account information, medical record number, or any other unique identifying number). In conducting our business, we will maintain records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you.

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I also understand the disclosed information may be subject to redisclosure by the recipient and no longer protected by federal privacy regulations.

Patient Name:_____ **DOB:**_____ **SSN:**_____

I authorize Holston Medical Group to *release* copies of my records *to*:

Name of Physician or Institution, etc.

Address

City, State, Zip

Which dates of treatment do you need records for?

****Please check all that apply:**

****Information to be Released:**
_____ Office Notes
(Encounter Notes, Telephone Notes, Memos)
_____ Radiology Reports
(X-rays, CT Scans, MRI, Ultrasound,etc.)
_____ Lab Results
_____ Immunization Record
_____ Consultations/Referrals
_____ Other _____

I authorize Holston Medical Group to *obtain* copies of my records *from*:

Name of Physician or Institution, etc.

Address

City, State, Zip

Which dates of treatment do you need records for?

Please send requested records to:

****Information will be used/disclosed for the following purpose(s):**
_____ Continuation of Care (for another provider)
_____ Personal Use
_____ Other_____

The patient or the patient's representative must read and initial the following statements:

_____ 1. I understand that the information in my health record may contain information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about psychiatric services, and treatment for alcohol and drug abuse.

_____ 2. I understand that my health care and the payment for my health care will not be affected if I do not sign this form.

_____ 3. I understand that I may revoke this authorization at any time by notifying *HMG* in writing. If I do revoke the authorization, it will not have any effect on any actions taken by *HMG* prior to their receipt of the revocation. Unless otherwise noted, I understand this authorization will expire ninety days from the date of my signature.

_____ _____
Signature of patient or patient's representative Date

_____ _____
Printed name of patient or patient's representative Relationship to patient

HMG.650

For Internal Use Only: Photo ID provided _____Yes _____No If No, attach a copy of the form used to validate the signature.