



PLEASE HAVE COPY OF IDENTIFICATION

Medical Record # _____
Account Number _____
Dates of Treatment _____

PHONE: 615-384-1542
FAX: 615-382-3803

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT IDENTIFICATION

Name _____
Date of Birth _____ Social Security # _____
Maiden/Other names known by _____

PROVIDER: NORTHCREST MEDICAL CENTER

RELEASE RECORDS TO: Name _____
Address _____
City/State/Zip _____

Table with 2 columns: INFORMATION REQUESTED FROM and TYPE OF INFORMATION REQUESTED. Includes categories like accounting of disclosure, billing, care center, emergency room, home health, hospital stay, other media, physician progress notes, operative report, history and physical, pathology report, discharge summary, other, nurses notes, X-ray report, EKG report, lab report, immunization.

PURPOSE OF RELEASE: ___ medical care ___ insurance ___ at the request of the patient
___ other, please explain _____

I understand that my medical record may also include information on diagnosis/treatment related to psychiatric or psychological conditions, drug or alcohol abuse, acquired immune deficiency syndrome, or HIV status. I understand and agree that the information, if any, pertaining to such diagnosis/treatment described above may be released.

PLEASE INITIAL THE STATEMENT THAT APPLIES (REQUIRED)
___ I DO ___ DO NOT AUTHORIZE THIS INFORMATION TO BE RELEASED.

Limitations, if any _____

TIME LIMIT: I understand this authorization may be revoked in writing at any time, except to the extent that action has taken place in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition _____.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE _____ DATE: _____

RELATIONSHIP TO PATIENT _____ WITNESS _____

PLEASE NOTE: When your medical information is released pursuant to a valid authorization, you should be aware of the following: That the information may be subject to re-disclosure by the recipient and may no longer be protected by the Privacy Rule. TREATMENT MAY NOT be withheld or conditioned on obtaining this authorization as is prohibited by the Privacy Rule.