NorthCrest MEDICAL ◆ CENTER

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 _____

INFORMATION REQUESTED FROM:

___accounting of disclosure
___billing
___care center
___emergency room
___home health
___hospital stay
___other media (films, videos, photos)

TYPE OF INFORMATION REQUESTED:

___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.