Allergy & ENT Associates of Middle Tennessee, P.C
EST. 1973

G. Lee Bryant, Jr., M.D., F.A.A.O.A.
D. Scott Fortune, M.D., F.A.A.O.A.
Justin E. Morgan, M.D.

Board Certified, American Board of Otolaryngology
Fellows, American Academy of Otolaryngic Allergy

Adult and Pediatric Diseases of the Ear, Nose, and Throat • Head & Neck Surgery
Allergy Testing and Treatment • Hearing and Balance Disorders

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(All sections must be completed)

I hereby authorize _____ _____and its physicians, employees, and agents to release or disclose to the below-named recipient all of my medical records including any specially protected records.

Patient Name: _____DOB:_____MRN:_____

I hereby authorize the release of medical records to: _____

_____

Purpose of disclosure: _____

"At the request of the individual" is sufficient when the patient initiates the authorization and elects not to provide a statement of purpose.

This request and authorization applies to:

- ❑ All medical records
- ❑ Health care information relating to the following treatment, condition, or dates of treatment:

  _____
- ❑ Specific records to be released (eg. Labs, imaging reports, other):

  _____

If you DO NOT WANT certain portions of your medical records released, please initial the box for the information you do not want released.

_____Substance abuse _____ Psychological or psychiatric treatment ____HIV/AIDS/STD

The authorization will expire on: _____

Date or Event may not exceed one year

I understand I have a right to revoke this authorization by written notification to the Privacy Officer, except to the extent it has acted in reliance thereon before notice of revocation. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure which may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization.

I understand that under most circumstances a healthcare provider may not condition treatment, payment, enrollment or eligibility for benefits on my signing this authorization. However, I understand that signing an authorization that permits the use and/or disclosure of my protected health information for research purposes may be a condition of my treatment if I am undergoing research related treatment. Also, I may be required to sign an authorization if my treatment is provided solely for the purpose of creating protected health information for disclosure to a third party. And under some circumstances, a health plan may condition my enrollment in a health plan or my eligibility for benefits on my providing an authorization permitting the health plan to make enrollment and eligibility determinations.

I have had the chance to read and think about the content of this authorization form and agree with all statements made in this authorization. I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of the protected health information noted in this form with the people and/or organizations named in this form.

_____

Signature of Patient or Authorized Representative — Date Signed

_____Relationship to Patient