Cumberland Family Care, PC

457 Vista Drive ● Sparta, TN 38583

PF-3000

Authorization of Use/Release of Protected Health Information

(This form applies only to the release and disclosure of Information. It Is not a consent for treatment or Intended for any other purposes.)

- By signing this form, I authorize Cumberland Family Care, PC to use, release or disclose the protected health information described below to:

Name of Person and/or Organization to Whom Information Should be Sent_____

Address_____

Street City State Zip Code

- Expiration Date of Authorization

This authorization Is effective ___/___/___unless revoked or terminated earlier by the patient or the patient's personal representative. This authorization expires upon fulfilment of request unless special circumstances are Indicated.

Purpose of disclosure (at request of patient, employment, life or disability Insurance, etc.):_____

I authorize the following Information to be sent to the address above {please (√)}:

- ❑ Copies of all medical records for the period ___/___/___ to ___/___/___
  Mo Day Yr Mo Day Yr
- ❑ Copies of the Information described below for period ___/___/___ to ___/___/___
  Mo Day Yr Mo Day Yr
- ❑ History & Physical Examination ___Lab/X-ray, etc. Reports ___Reports from other Physicians
- ❑ Other (Please Specify)

- I understand that this Information my Include any history of acquired Immunodeficiency syndrome (AIDS); sexually transmitted diseases; human Immunodeficiency virus (HIV) Infection; behavioral health service/psychiatric care; treatment of alcohol and or drug abuse; or similar conditions.
- I understand that I may request certain Information ***not*** be released, even If occuring during the dates above. (Please specify Information you do not want released)_____
- I understand that Information that Is disclosed under this authorization may be disclosed again by the person or organization to whichh It Is sent. It may not be possible to ensure your right to the protection of the privacy of this Information once Cumberland Family Care, PC discloses It to another party.

I have been provided a copy of Cumberland Family Care, PC's *Notice of Privacy Practice* and any charges that may be associated with this authorization. I have the right to Inspect or copy Information used or disclosed under this authorization; and I have the right to refuse to sign this authorization.

Patient's Signature_____ Date_____

Patient Name (Print)_____ SS#_____

Date of Birth_____ Witness_____ Date_____

Signature of Patient Representative_____

Relationship of Patient Representative to Patient_____

Dev. 03.03.03