# SOUTHERN TENNESSEE
# FIRST CHOICE HEALTH

**I hereby authorize _____and its providers, employees, and agents to release or disclose below Named person or organization my medical records.**

**RELEASE RECORDS TO: _____**

_____

_____

**Phone: _____Fax: _____**

**Patient's Name: _____**

**Date of Birth: _____ SS Number: _____**

**Purpose of Disclosure: _____**

**INFORMATION AUTHORIZED TO BE RELEASED**

1. **Only records generated by the above named healthcare provider not including records received from other sources……INITALS: _____**
2. **Only a portion of records maintained by the above named healthcare provider. (date of treatment, please specify_____**
3. **All records at this facility……..INITALS: _____**
4. **Any and all billing information……INITALS: _____**
5. **Any and all insurance information……INITALS: _____**

**Other specific information NOT TO BE RELEASED:**

**_____**

**This authorization will expire on the following date or upon the occurrence of the following event**

**_____**

**I understand that I may revoke the authorization at any time prior to the expiration date or event but that my revocation will not have any effect on actions taken by the above named healthcare provider or its provider's employees or agents before they received my revocation. Should I desire to revoke this authorization, I must send written notice to the named healthcare provider.**

**I understand that I am not required to sign this authorization. The above named healthcare provider will not condition treatment, payment, enrollment, or eligibility for benefits on whether I provider this authorization.**

**I understand that my records may be subject to disclosure by the recipient and may no longer n=be protected by the federal privacy regulations. I understand that this authorization does not limit the above named healthcare provider or its provider's, employee, or agents ability to use or disclose my information for treatment payment or healthcare operations or as otherwise permitted by law.**

**I understand that a photocopy of this authorization is to be considered as the original.**

**Patient or authorized representative's signature: _____**

**Date: _____Relationship to patient_____**