AUTHORIZATION TO RELEASE INFORMATION

Patient's Name:______________________________
Patient's Address:____________________________
City, State, Zip:______________________________
Date of Birth:____________ Telephone No:_____________
Medical Record #:_____________________________

HighPoint Neurology Associates
225 Big Station Camp Blvd Ste 211
Gallatin, TN 37066
P(615)328-3550 F(615)328-3559

SS#_____________________________

Release Of Information From HNA

☐ I authorize HighPoint Neurology Associates to release copies of my medical records as listed below. The information should be sent to:

____
Name of physician, Institution, Self, etc.

____
Address

____
City, State, Zip

______________ ______________
Telephone Number Fax Number

Release Of Information To HNA

☐ I authorize the release of information from:

____
Name of Physician, Institution, Self, etc.

____
Address

____
City, State, Zip

______________ ______________
Telephone Number Fax Number

DATES OF TREATMENT (Which dates of treatment do you need records for?)
Dates:____
The information that is to be released should be detailed to specific dates of service, treatment, etc. A meaningful description of the information to be disclosed should be provided.

***Please note that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Highpoint Health Systems*.**

Information to be Released

- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Operative Report
- ☐ X-ray
- ☐ Clinic Visits
- ☐ ER Records
- ☐ EKG
- ☐ Lab
- ☐ Physician Orders
- ☐ Continuity of Care Documents (CCD)
- ☐ Other

Purpose of Release

- ☐ Attorney
- ☐ Social Security
- ☐ Continuation of care
- ☐ Workmen's Compensation
- ☐ Disability
- ☐ Insurance
- ☐ Deposition
- ☐ Billing
- ☐ Other (Please Specify)

Expiration date for expressed authorization is ______________. If the patient does not express a desire for a specific date or condition to their authorization, this authorization will expire 90 days from the date signed by the patient or legal representative.

I have read, or have had read to me, the above statements, and understand them as they apply to me. I further understand that I may revoke this authorization at any time except to the extent that action has already been taken in accord with this authorization. Revocation by the patient or legal representative is allowable only in the event that release of information has not already occurred. Specific exceptions to revoke an authorization exists, as detailed by federal law, such as:

- HNA has taken action in reliance thereon or
- The authorization was obtained as a condition of obtaining insurance coverage, whereby another law provides the insurer with the right to contest a claim under the policy.
  In order to revoke an authorization, a written document stating the intent of the patient to revoke such authorization must be either presented in person to or delivered by certified mail to the privacy officer or HighPoint Neurology Associates. This revocation document must contain signature of the patient or patient's legal representative. I understand that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization.

______________________________ ______________
Signature of Patient or Appropriate Legal Representative Date

____
If applicable, relationship to patient photo ID was provided_______ yes________no If no, the form of patient identification must be so stated and a copy provided with the authorization. In order to be valid, the signature on the authorization must be after the date of service that is being requested for release.

______________________________ ______________
Witness Date