

AUTHORIZATION TO RELEASE INFORMATION

Patient's Name: _____
 Patient's Address: _____
 City, State, Zip: _____
 Date of Birth: _____ Telephone No: _____
 Medical Record #: _____

HighPoint Neurology Associates
 353 New Shackle Island Rd., 128B
 Hendersonville, TN 37075
 P(615)822-8908 F(615)822-8909

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

- | | |
|---|---|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> EKG |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Lab |
| <input type="checkbox"/> Operative Report | <input type="checkbox"/> Physician Orders |
| <input type="checkbox"/> X-ray | <input type="checkbox"/> Continuity of Care |
| <input type="checkbox"/> Clinic Visits | <input type="checkbox"/> Documents (CCD) |
| <input type="checkbox"/> ER Records | <input type="checkbox"/> Other |

Purpose of Release

- | | |
|---|---|
| <input type="checkbox"/> Attorney | <input type="checkbox"/> Disability |
| <input type="checkbox"/> Social Security | <input type="checkbox"/> Insurance |
| <input type="checkbox"/> Continuation of care | <input type="checkbox"/> Deposition |
| <input type="checkbox"/> Workmen's | <input type="checkbox"/> Billing |
| <input type="checkbox"/> Compensation | <input type="checkbox"/> 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