

PATIENT INFORMATION:

329 Wesley Street, Johnson City, TN, 37601 | Phone 423.631.0055 | Fax 877.409.2095

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Last Name: _____

	First Name:							
	Date of Birth:							
I AUTHORIZE RELEASE FROM:	Office/Clinic Name:							
Records from ALL clinics, excluding Mental Health, will be released if clinics are not specified on the attached list.								
TO RELEASE INFORMATION TO:	Name: KidsFirst Children's Urgent Care							
	Address: 329 Wesley Street							
	Johnson City TN, 37601							
	Phone: 423.631.0055							
	Fax: 877.409.2095							
PURPOSE OF DISCLOSURE:	() Transfer of Care							
	() Payment of Claim							
	() School							
	() Legal							
	() Personal Use							
	() Other (specify):							
RELEASE METHOD:	() Mail							
	() Fax							

() Pick-up

INFORMATION TO BE RELEASED:	Between dates of: and Routine Record Set:								
	() All Records (<i>Immunization Records</i> , Provider Notes, Procedure Reports, H&P Exam, Discharge Summary, Radiology/Diagnostic Reports, Lab Reports)								
	() Discharge Summary () Orders								
	() H&P Exam/Initial Evaluation () Radiology Reports								
	() Consultation Report () Radiology Films								
	() Progress Notes/ Provider Notes () Diagnostic Test Reports								
	() Condition Report () Procedure Reports								
	() Lab/Pathology Reports () Immunization Records								
	() Itemized Billing Statement								
	() Other (specify content/dates):								

ACKNOWLEDGEMENT OF UNDERSTANDING:

- I understand the expiration date of this authorization is one year after the date signed.
- I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken.
- I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.
- I understand by authorizing this use or disclosure of information, there will be no conditions placed on my health care or payment for my health care.
- I understand that I may be required to pay a fee for retrieval and photocopying of records and/ or supervising inspection of medical records.
- I understand that my medical information may include information relating to sexually transmitted diseases, sickle cell anemia, AIDS, HIV, behavioral or mental health services and treatment for alcohol and drug abuse.

	mental	health	n services	and	treatment	for	alcohol	and	drug	abuse.	
Signatur	e of pati	ent or 1	Legally autho	rized	representati	ve)	(Rela	tions	nip)	-	(Date)