MIDDLE TENNESSEE EAR, NOSE & THROAT
1370 Gateway Blvd. Suite 100
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Physician to provide records: _____

Phone# _____ Fax# _____

Patient's name: _____Patient's SS#: _____DOB: _____

Doctor/facility to receive records _____
Address _____
City, State & Zip: _____
Fax: _____

Specific description of information (including dates: **Initials**

1. Only records generated by this facility (not including records received from other sources:)……..____
2. Only some portion of records maintained at facility (dates of treatment, etc. specify below)……..____
3. **All medical records at this facility** ……____

IF YOU DO NOT WANT CERTAIN PORTIONS OF YOUR MEDICAL RECORDS RELEASED, PLEASE READ THIS SECTION CAREFULLY AND INITIAL THE BOXES FOR INFORMATION YOU DO NOT WANT RELEASED OTHERWISE, YOUR RECORDS WILL BE RELEASED AS SPECIFIED ABOVE.

Purpose of Disclosure: ____Patient's request____Changing Physicians____Moving____Physician/Audiologist Request
Other (Please specify) _____

*I understand that I have the right to refuse to sign this form and that my refusal will not result in the physician conditioning the provision of healthcare with two exceptions:
1. If it is for disclosure of information created for the sole purpose of disclosure to a third party, my refusal my result in the doctor declining to provide the healthcare which is for the sole purpose of creating protected health information for disclosure to a third party.
2. If it is for disclosure of information created for research that includes treatment, my refusal may result in the physician declining to provide the research-related treatment. **Patient initials**: _____

***Authorization of Medical Records:** I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to the Middle Tennessee Ear, Nose and Throat, PC. I understand that, by signing this form, I am confirming my authorization that the Middle Tennessee Ear, Nose and Throat, PC may use and/or disclose to the persons and /or organizations named in this form the nonpublic personal health information described in this form. I do understand that I will receive a copy of this if so requested.

***Right to Revoke:** Expiration or revocation of authorization-I understand that I may revoke this authorization at any time and that unless an earlier date is specified it will automatically expire 12 months after date affixed below. Use of copies - A copy of this authorization may be utilized with the same effectiveness as an original.

_____ _____
Patient name (print): Person authorized to sign for patient (print):

_____ _____ _____
Patient's Signature Signature Relationship to patient

Date:_____ Date:_____