# MEDICAL CARE, LLC

Account: _______________

www.medicalcarellc.com

Done: _______ By: _______

**PHONE (423)543-2584 • FAX (423)542-5109**

## AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

**Patient Name:** ____________________________________________

**Date of Birth:** ______________________ **Social Security:** ______________________

**1.** I authorize the use or disclosure of the above named individual's health information as described below:

**2.** The following individual or organization is authorized to **release/receive** the authorized health information:

**Group Name:** ______________________ **Physician Name:** ______________________

**Address:** ____________________________________________

**Phone Number:** ______________________ **Fax Number:** ______________________

**3. Medical Care, PLLC** is authorized to **release/receive** the authorized health information:

**Medical Care, LLC**
**1900 West Elk Ave** **or** **Fax: 542-5109**
**Elizabethton, TN 37643** **(40 pages or less)**

**4.** The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

- O Problem list
- O Medication list
- O List of allergies
- O Immunization record
- O Most recent history and physical
- O Most recent discharge summary
- O Laboratory results from (date) _____/______/_____ to (date) _____/______/_____ or All ____
- O Radiology reports from (date) _____/______/_____ to (date) _____/______/_____ or All ____
- O Entire record (unless otherwise specified this will be for the last 18 months of records)
- O Other____________________________________________

**5.** I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

**6.** This information may be disclosed to and used by the following individual or organization for the purpose of medical treatment: **MEDICAL CARE, LLC • 1900 West Elk Ave. • Elizabethton, TN 37643**

**7.** I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

**Unless otherwise revoked, this authorization will expire on the following date:** ______________________

**If I fail to specify an expiration date, event or condition, this authorization will expire in six months.**

**8.** I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information I can contact medical records.

______________________________ ______________________
**Signature of Patient or Legal Representative** **Date**

______________________________ ______________________
**If Signed by Legal Representative, Relationship to Patient** **Signature of Witness**

**Please send records to: MEDICAL CARE, LLC • 1900 West Elk Ave.**
**Elizabethton, TN 37643 • Fax: (423) 542-5109 (40 pages or less)**