AUTHORIZATION FOR RELEASE OF INFORMATION

The Plastic Surgery Group, P.C.
979 East Third Street, Suite C-920 Chattanooga, Tenn. 37403
Phone: 423-756-7134 **Fax:** 423-763-4571

I hereby authorize the use or disclosure of my health information as described below. I understand the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.

Patient name: _____ DOB: _____
Medical Record #_____ Physician Name: _____
Persons/organizations providing the information:
_____
_____
_____
_____
Persons/organizations receiving the information:
Name:_____
Address:_____
_____
Phone:_____
Specific description of information (including date(s): _____
_____
_____
What is the purpose of the use or disclosure? _____
_____
(Note: "at the request of the individual" is a sufficient description of the purpose when the patient initiates the authorization and elects not to provide a statement of the purpose.)

The healthcare provider requesting the authorization will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.

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. Refusal to sign this authorization, if it is for disclosure of information created for research that includes treatment, may result in the physician declining to provide the research-related treatment. 2. Refusal to sign this authorization, if it is for disclosure of information created for the sole purpose of disclosure to a third party, may 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.

I understand that this authorization will expire in 12 months from the date of signature or with the following event:_____

I understand that I may revoke this authorization at any time by notifying the healthcare provider in writing. The revocation will only be effective from the date it is received in this office and will not apply retroactively.

I understand that I will that I will receive a copy of this signed authorization.

_____
Signature of patient or patient's representative Date
(*Pertinent sections of the Form MUST be completed before signing*.)

Printed name of patient's representative: _____

Relationship to the patient: _____