CAMPBELL CLINIC ORTHOPAEDICS
MEDICAL RECORDS DEPARTMENT
Phone: (901) 759-3100 **Fax:** (901) 759-3193
1400 S Germantown Rd
Germantown, TN 38138

AUTHORIZATION FOR RELEASE OF INFORMATION

Pick Up ☐ Mail ☐ Fax ☐

For information about how your medical information may be used or disclosed, please see the Patient Notice. You have the right to review the Notice before you decide to sign this form. The Notice is subject to change. You may request a copy of the Notice from the Privacy Officer of Campbell Clinic. The Notice is also posted at Campbell Clinic's office and on our website at www.campbellclinic.com.

- **YOU HAVE THE RIGHT TO INSPECT, COPY AND/OR AMEND INFORMATION TO BE USED OR DISCLOSED.**
- **YOU MAY REFUSE TO SIGN THIS FORM, HOWEVER IT MAY PREVENT US FROM COMPLETING A TASK YOU HAVE REQUESTED *(such as enrollment in research study or examining you to create a report for your attorney).***
- **WE WILL NOT CONDITION YOUR TREATMENT ON AN AUTHORIZATION, EXCEPT FOR AN AUTHORIZATION FOR RESEARCH-RELATED TREATMENT.**
- **WE MUST PROVIDE YOU WITH A COPY OF THIS AUTHORIZATION FORM UPON REQUEST.**

THIS AUTHORIZATION IS VOLUNTARY

TO BE COMPLETED BY PATIENT OR PATIENT REPRESENTATIVE

I, _____, **Date of Birth** _____, **SS#** _____,
(Print Patient's Name)

Address _____, **Phone #** _____ do hereby authorize Campbell Clinic to obtain, use, disclose or receive my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization to whom I authorize disclosure of my personal data and/or individually identifiable health information is not a health plan, health care provider, or clearinghouse that the released information may no longer be protected by federal privacy regulations.

PATIENT OR PATIENT REPRESENTATIVE PLEASE CHOOSE AND INITIAL A, B, or C

_____ A ***COMPLETE MEDICAL RECORD*** *that may contain treatment notes regarding radiology, pathology (including HIV test results and genetic testing information), immunization, procedure(s), alcohol and drug abuse records protected by Federal Confidentiality Rules 42 CFR Part 2, and other common medical record documentation made by the physician, nurse or other ancillary personnel for the entire time I was treated by the practice:*

_____ B Description of records to be released: (**specific doctors, time period, tests or procedures**): _____

_____

_____ C Electronic copy of health information (In accordance with Federal requirements to demonstrate meaningful use of EHR)

***Include Images (CD's) of Radiology Procedures?* Yes No**

TO BE COMPLETED BY PATIENT OR PATIENT REPRESENTATIVE

Release my records to the following:

Name _____ **Fax#** _____

Complete Address _____ **Phone#** _____

For the purpose(s) of: _____

I understand that I may withdraw my authorization in writing to the Privacy Officer of Campbell Clinic at any time, except to the extent that action has been taken in reliance on this statement. I understand that even if I do not withdraw authorization that this statement will expire ***one (1) year from this date.*** I have carefully read and understand the above, and do herein expressly and voluntarily authorize the disclosure of the above information about, or medical records of, my condition to those persons or agencies listed above.

_____ _____
Signature of patient or patient's representative **Date**
(Form MUST be completed before signing.)
Printed name of patient's representative _____
Description of the Representative's authority to act for the patient _____
Relationship to the patient: _____