CENTRAL TENNESSEE
EAR, NOSE & THROAT
787 Weatherly Dr. Suite 200
Clarksville, TN 37043
(931)647-1255 Fax: (931)647-2399

Medical Records Release Authorization

I hereby authorize, Central Tennessee Ear, Nose & Throat, PLC, its physician, employees and agents to release or disclose the below named all of my medical records including those relating to psychiatric and/or mental conditions, drug and/or alcohol abuse or HIV infections.

Please choose your preference:

_____ I will pick up copies.

_____ I wish to have the copies faxed/emailed to _____

_____ I wish to have the copies mailed to _____

_____

Patient's name: _____ Date of Birth: _____

Purpose of disclosure: _____

Information to be disclosed (check all that apply):
___ **All Medical Records**
___ **Treatment Records**
___ **Diagnostic Records**
___ **Only records generated by the above physician (not including records received from other sources.)**
___ **Other:** _____

If you DO NOT WANT any of the following portions of your medical records released please initial in the space provided. Otherwise, your records will be released as specified above.

_____ Substance Abuse, if any _____ Behavioral Health _____ AIDS/HIV/STD, If any

I understand that I may revoke the authorization at any time prior to the date of expiration, but that my revocation will not have any effect on actions taken by Central Tennessee Ear, Nose and Throat, employees or agents before they receive my revocation. Should I wish to revoke this authorization, I must send written notice to the above-named health care provider. I understand that I am not required to sign this authorization. The above-named health care provider will not condition treatment, payment, enrollment or eligibility for benefits on whether I provide this authorization.

I understand that my records may be subject to disclosure by the recipient and may no longer be protected by federal privacy regulations.

_____

Signature of Patient Date