STAT Wellness Center, PLLC

1225 Hampshire Pike
Columbia, TN 38401
(931) 982-6333

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name:_____ DOB:_____
Address_____
City:_____ State:_____ Zip:_____

I hereby authorize_____ to disclose the following information:
(name of organization releasing information)

_____
(address, phone & fax number if available)

I hereby authorize disclosures of the following information

_____Progress Notes
_____Consults
_____Laboratory Reports
_____Financial Records
_____Two most recent years
_____X-ray and imaging reports
_____Immunization records
_____Complete (all health information)
_____Other

I understand this will include information relating to (check if applicable)
_____AIDS/HIV (Acquired Immunodeficiency Syndrome/Human Immunodeficiency Virus)
_____Mental health or psychiatric care
_____Substance or alcohol abuse treatment

This information will be disclosed to: STAT Wellness Center, PLLC
Amy N. Harris, FNP

For the purpose of_____.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing. I understand that revocation will not apply to information that has already been released in response to this authorization.

This authorization will expire on the following date, event or condition_____.
If I fail to specify an expiration date, event or condition this authorization will expire in one year.

I understand that authorizing the disclosure of my health information is voluntary. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by the federal confidentiality rules.

_____
(Signature of Patient or Legal Representative) (Date)

_____
(If signed by Legal Representative, relationship to patient) (Date)