Authorization for Disclosure of Protected Health Information

Purpose and Laws: This form, when properly completed, permits the release of confidential information about a person receiving services (service recipient) governed and regulated by Title 33, Tennessee Code Annotated. Any information to be released under this form shall be released in accordance with the following confidentiality laws and regulations: Title 33, Tennessee Code Annotated; the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its regulations at 45 Code of Federal Regulations (CFR) Parts 160 and 164; and the federal Confidentiality of Alcohol and Substance Abuse Patient Records and its regulations at 42 CFR Part 2. The records released through this Authorization are protected by the above named confidentiality laws and regulations. A general authorization for the release of medical or other information is NOT sufficient for the purpose of disclosing mental health or alcohol and substance abuse information. Federal rules restrict any use of alcohol and substance abuse information to criminally investigate or prosecute the person to whom the information pertains. Further disclosure of this information to parties other than those designated on this form is expressly prohibited without the express written consent of the person to whom the information pertains.

Patient Name (Printed): _____ DOB: ____/____/____

Instructions: Fill out form in its entirety. If any section is incomplete, this form may be invalid, and the request may not be processed.

Request information from:	**Request information to:**
Provider/Facility Name:	Provider/Facility Name: Omega Pain Management
Address:	Address: 6348 Lonas Spring Dr
City/State/Zip:	City/State/Zip: Knoxville TN
Phone Number:	Phone Number: 865-337-5137
Fax Number:	Fax Number: 888-839-6922

Purpose of Release: ☐ Continuing Care ☐ Other: _____

Information to be Released: Service Dates: From: _____ To: _____
☐ Entire Medical Record ☐ Lab Reports ☐ Operative/Procedure Notes ☐ Radiology Reports ☐ Records pertaining to HIV or Hepatitis ☐ Psychiatric Records ☐ Office Visit Notes ☐ Billing Statements ☐ Other (Please Specify):

_____

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION

By signing this form, I (the service recipient) understand that if the person or organization designated on this form to receive the information is not a Health Plan or Health Care Provider, some of the released information may no longer be protected by the above named confidentiality laws and regulations. I also understand that signing this Authorization is voluntary, and that I am not required to sign this Authorization in order to get treatment, payment, enrollment, or eligibility for benefits. I also understand that I may revoke this Authorization by doing so in writing at any time; except to the extent that action has been taken in reliance on the information, and that the revocation does not affect any information that was released before the revocation. Even if I do not revoke this Authorization, the Authorization expires automatically one (1) year from the date of signature or as follows: _____

Patient Signature: _____ Date: _____

Signature of Person Acting On Behalf of Patient:: _____ Date: _____

Patient is: ☐ Incompetent ☐ Disabled ☐ Deceased Legal Authority: ☐ Legal Guardian ☐ Power of Attorney ☐ Next of Kin

*If the individual signing this form is acting on behalf of the service recipient, the individual is: (1) the parent, legal guardian, or legal custodian of a service recipient who is under 18 years of age; (2) the conservator or guardian for the service recipient; (3) the guardian ad litem of the service recipient but only for the purposes of the litigation in which the guardian ad litem serves; (4) the attorney-in-fact under a power of attorney who has the right to make disclosures under the power for the service recipient; (5) the executor, administrator, or personal representative on behalf of a deceased service recipient; and (6) the treatment review committee, acting within the authority and scope of Tennessee Code Annotated Section 33-6-107. Appropriate documentation of proof of this individual's authority to act on behalf of the service recipient must be submitted to the entity being asked to release the information before any information will be released.