PARKWAY CARDIOLOGY ASSOCIATES, P.C.
AUTHORIZATION TO RELEASE INFORMATION

Section A: Must be completed for all authorizations

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: ______________________

Persons/organizations providing the information:

Parkway Cardiology

80 Vermont Ave., Oak Ridge, TN 37830

Phone: (865) 482-4078

Fax: (865) 425-0480 (Medical Records)

(865) 482-4033 (Nurse's Station)

Person/organizations receiving the information:

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Specific description of information (including date(s)): ______________________

What is the purpose of the use or disclosure?: ______________________
(Note: "at the request of the individual" is sufficient description of the purpose when the patient initiates the authorization and elects not to provide a statement of the purpose.)

Section B: Must be completed only if the healthcare provider has requested the authorization:

1.The provider must complete the following statement:

a.Will the healthcare provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? Yes: _____ No: _____

2. The patient must read and initial the following statement:

a. I understand that I get a copy of this form after I sign it. Pt. initials: _____

Section C: Must be completed for all authorizations:

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 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 healthcare which is for the sole purpose of creating protected health information for a disclosure to a third party.
Pt. initials: ______

I understand that this authorization will expire on the following date ___/___/___ (MM/DD/YY) 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.
Pt initials: ______

☐ I would like a copy of my protected health information. I understand that Parkway Cardiology Associates may charge me a fee for the copies as set forth in the following schedule: $20.00 for pages 1 – 40, and $.25 per page for each additional page. I also understand that I may be required to pay the fee in full before I obtain the copy.

______________________ ______________________

Signature of patient or patient's representative Date

(pertinent sections of the form MUST be completed before signing)