Patient Authorization for Disclosure of Protected Health Information

Patient Name:	Date of Birth:
Address:	

I hereby authorize McMinn Clinic, Inc. and/or MedHelp, P.C., acting as custodian of the records for McMinn Clinic, Inc. (collectively, the "Practice"), to disclose the above-named patient's health information to the following:

Name: _____
Address: _____
_____
Phone: _____

Specific description of the health information to be disclosed (*include dates of service, i.e., appointment date, type of service, etc):* _____
_____

This health information is to be disclosed for the following purpose (*if Authorization requested by the patient put: "At the request of the individual"*): _____
_____

By providing this Authorization, I understand as follows:

1. **I understand that this Authorization may result in the sending of clinical information and x-rays with reference to the above-named patient's diagnosis and/or any alcohol, drug or child abuse problems, behavioral or mental health services, and/or information concerning sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency syndrome (HIV). I understand that these records are strictly confidential and are solely for the information of the person to whom addressed.**

2. I understand that this Authorization is voluntary. I may refuse to sign this Authorization and the above-named patient's treatment and/or payment obligations will not be affected unless either of the following applies:

   - The treatment is related to research and the use and/or disclosure is related to such research; or
   - The treatment is solely for the purpose of creating protected health information for disclosure to a third-party.

3. I understand that the health information to be released may be subject to redisclosure by the recipient of the health information and no longer protected by federal or state law.

4. I understand that this Authorization is continuous in nature and is to be given full force and effect, including disclosing and/or utilizing any and all of the foregoing information learned or determined after the date hereof but prior to the expiration date noticed below.

5. I understand that I may revoke this Authorization at any time by notifying the Practice in writing, but if I do, it will not have any effect on uses or disclosures prior to the receipt of the revocation. Unless otherwise revoked, this Authorization will expire in one (1) year.

6. I understand that, upon request, I may receive a copy of this Authorization form after I sign it.

7. I understand that a photocopy or facsimile of this Authorization shall be valid and effective, just as the original.

_____ _____
Signature of Patient or Patient's Representative Date

_____
Printed Name of Patient's Representative (*if applicable*)

_____
Representative's Relationship to Patient (*if applicable*)