

Feagins Medical Group, PLLC
1916 Patterson Street; Suite 310, Nashville, TN 37203
Ph 615-712-7013 Fax Numbers: 615-712-7026

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Please Note: This form must be completed in its entirety. Leaving any section blank will invalidate this form and make it unusable. Please read the statement on the reverse side of this form before you sign below.

Patient Name: _____
First Middle Last

Date of Birth _____ SS# _____

Street Address _____

City: _____ State: _____ Zip _____

I authorize Feagins Medical Group, PLLC to use and disclose the following Protected Health

Information covering the dates of service from ___ / ___ / ___ thru: ___ / ___ / ___
month Day Year month Day year

- | | |
|--|--|
| <input type="checkbox"/> Entire Chart | <input type="checkbox"/> Progress notes |
| <input type="checkbox"/> Discharge summaries | <input type="checkbox"/> Mental or behavioral health records |
| <input type="checkbox"/> Lab results | <input type="checkbox"/> Genetic test results |
| <input type="checkbox"/> History and physical exam | <input type="checkbox"/> Dental records |
| <input type="checkbox"/> Consultation reports | <input type="checkbox"/> Obstetrics records |
| <input type="checkbox"/> X-ray reports | <input type="checkbox"/> Procedure notes |
| <input type="checkbox"/> HIV/AIDS test results and treatment | <input type="checkbox"/> Operative and pathology reports |
| <input type="checkbox"/> Alcohol and other drug treatment | <input type="checkbox"/> Medication list |
| <input type="checkbox"/> Immunization record | <input type="checkbox"/> Prior hospitalization(s) |
| <input type="checkbox"/> Summary of treatment | <input type="checkbox"/> Billing and payment history |
| <input type="checkbox"/> Other specify below | |

I understand this information will be disclosed to the following Recipient or the following category of Recipients:

The information will be disclosed for the following purpose: (Not required if being disclosed to the patient)

I understand that Feagins Medical Group, PLLC

will will not be compensated for this disclosure

Signature of the Patient

Date Signed

Signature of the Patient's Representative/ Legal Guardian

Date Signed

If Patient's Representative please describe authority to act on behalf of the individual:

Witness / Relationship to Patient

Date Signed

For your protection:

- We cannot condition our provision of services or treatment to you based on the receipt of this signed authorization;
- You may inspect a copy of this protected health information to be used or disclosed with reasonable notice and payment of copying cost;
- You may refuse to sign this Authorization; and
- We must provide you with a copy of this signed Authorization.
- You have the right to revoke this Authorization at any time, provided that you do so in writing to: Feagins Medical Group, PLLC / c/o Contact-Person at 1916 Patterson Street; Suite 310, Nashville, TN 37203.
- We may continue to use the authorization to the extent that we have already used or disclosed the information in reliance on this Authorization.
- This Authorization will be considered valid for (1) one year from the date of your signature or until we are reasonably able to complete the purpose of this Authorization.
- I understand that if the person or entity that receives the above specified information is not a health care provider, health plan or health care clearinghouse covered by the federal privacy regulations or a business associate of these entities, the information described above may be re-disclosed and no longer protected by the regulations.