Angela L. Willis MD

Family Practice

AUTHORIZATION FOR USE OR DISCLOSURE OF INFORMATION

Patient Name: _____ Date of Birth: _____

Previous Name(s): _____ Social Security #: _____

I request and authorize **Dr. Angela Willis (Angela Willis Family Practice)** to release Healthcare information of the patient named above to:

_____
_____
_____
_____
_____

I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider covered by federal privacy regulations, the released information may no longer be protected by federal privacy regulations. The persons authorized to use or disclose information will not receive compensation for obtaining tis authorization.

This authorization applies to :

❑ All healthcare information held by the organization listed above about the patient listed above

❑ Healthcare information related to the following treatment, condition, or dates:

❑Yes ❑No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to Dr. Angela Willis. I Understand that Dr. Angela Willis will be notified that I must give specific written permission before disclosure of those test results to anyone. NOTE: STD (Sexually Transmitted Disease) includes herpes, human papilloma virus, genital warts, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphgranuloma venereum, HIV, AIDS, and gonorrhea.

❑Yes No I authorize the release of any records regarding drug, alcohol, or mental health treatment of Dr. Angela Willis

The purpose of this authorization is: _____

I understand that the persons hereby authorized to use or disclose information will not condition treatment, payment, enrollment in a health plan, or eligibility for benefits on my providing this authorization, except that if the purpose of this authorization is for research, refusal to sign this authorization may result in my being denied research-related treatment. I understand that I have the right to receive a copy of this authorization after I have signed it.

I understand that this authorization will expire on (complete one) ___/___/___ or the occurrence of the following event related to the purpose of this authorization: _____.

I understand that I may revoke this authorization at any time by notifying the HIPAA Privacy Officer in writing at 5651 Frist Blvd Suite 713 Hermitage,TN 37076. I understand that this revocation shall not be effective to the extent this authorization has already been relied upon, or if the authorization was obtained as a condition for health plan coverage and the health plan has a right to contest the coverage under applicable law.

Signature: _____ **Date: _____**

If not signed by patient:
Printed name of individual's representative: _____

Description of representative's authority to act for individual: _____