

**AUTHORIZATION FOR USE OR DISCLOSURE OF INFORMATION FOR PURPOSES
REQUESTED BY PHYSICIAN'S OFFICE**

I, _____, hereby authorize CORE Physicians to (check those that apply):

_____ use the following health information, and/or
_____ disclose the following protected health information to (name of entity or entities to receive information):

Specifically describe the information to be used or disclosed, including, but not limited to meaningful descriptors such as date of service, type of service provided, level of detail to be released, origin of information, etc.

- _____ Initial Examination
- _____ Discharge Summary
- _____ History and Physical
- _____ X-ray Films
- _____ Office Visit Notes All Dates: _____ to _____
- _____ Entire Medical Records **including** Psychiatric treatment, Alcohol or Drug Rehabilitation, HIV, Testing, Drug Screening
- _____ Entire Medical Records **excluding** Psychiatric treatment, Alcohol or Drug Rehabilitation, HIV, Testing, Drug Screening
- _____ Other (specify) _____

This protected health information is being used or disclosed for the following purposes: _____

This authorization shall be in force and effect for one year from the date signed below, at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to CORE Physicians at 1114 West 7th Street, Columbia, Tennessee 38401. I understand that a revocation is not effective to the extent that CORE Physicians has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

CORE Physicians will not require authorization for the requested use or disclosure of private medical information prior to treatment, payment.

- I understand that I have the right to:
- Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights).
 - Refuse to sign this authorization.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Description of Personal Representative Authority's

<p>Internal Use Only:</p> <p>If patient or patient's representative refuses to sign request to sign request form, please document the name, date, and time for the refusal.</p> <p>Name of Patient/Representative: _____</p> <p>Date: _____</p> <p>Witness: _____</p>
