Innovative Family Care PLLC

3300 Williams Enterprise Drive Suite 1
Cookeville, Tennessee 38506
Phone: 931-528-9222 Fax: 931-854-0907

Authorization for Disclosure of Health Information

Patient Name:_____ Date of Birth:_____
Address:_____ City:_____ State:_____ Zip:_____
Phone:_____ Cell Phone:_____

1. I authorize the use or disclosure of the above named individual's health information as describe below.

2. The following individual or organization is authorized to make the disclosure:
   Name:_____
   Address:_____ City:_____ State:_____ Zip:_____
   Phone:_____ Fax:_____

3. The type and amount of information to be used or disclosed is as follows:
   ____Last Office Note ____Special Studies ____X-Ray Reports
   ____Complete Health Records ____Lab Results
   ____Physical Exam ____Consultation Reports
   ____Immunization Record
   ____Other (Please Specify):_____

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

5. This information may be disclosed to and used by the following individual or organization.
   Name: Innovative Family Care
   Address: 3300 Williams Enterprise Drive Suite 1
   City: Cookeville State: TN Zip: 38506
   Phone: 931-528-9222 Fax: 931-854-0907
   For the purpose of: Continued Medical Treatment

6. I understand that I have a right to revoke this authorization at anytime. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:_____

7. If I fail to specify an expiration date, event, or condition, this authorization will expire in sixty days. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact:
   Innovative Family Care (931)528-9222

Signature:_____ Date:_____