Upper Cumberland Ear, Nose & Throat
Advanced care • Complete care • We care

Upper Cumberland Ear, Nose & Throat
100 West 4th Street, Suite 200
Cookeville, TN 38501
Phone: (931) 528-1575 or 800-539-7208
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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name**:** _____DOB**:**_____
Address**:** _____

To: (facility to release records): _____
_____
_____

Information to be released: _____
_____

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released unless I have initialed the lines below:

EXCLUDE the following information from the records release: (please initial)

_____ Substance abuse (including alcohol/ drug abuse)
_____ Mental health (including psychotherapy notes)
_____ HIV related information (AIDS related testing)
_____ Sexually transmitted diseases

Purpose of Disclosure: Treatment

Release records to: Upper Cumberland Ear, Nose & Throat
ATTN: _____
100 West 4th Street, Suite 200
Cookeville, TN 38501

I understand this authorization will expire on _____ (one year after signing). I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective the date notified except to the extent action has already been taken in reliance upon it. I understand that information used or disclosed pursuant to this authorization may be subject to re- disclosure by the recipient and no longer be protected by Federal Privacy Regulations.

_____ _____
Patient Signature (or guardian/ representative) Date

_____
Witness Signature