Onsite
Employee Health and Wellness
350 Pageant Lane Ste 307
Clarksville, TN 37040
Phone: (931) 906-2001
Fax: (931) 648-5618

Authorization for the Release of Medical Information

Patient's name: _____ Date of birth: _____

☐ I authorize ***Onsite Employee Health & Wellness*** to send a copy of my medical records to:

Provider's Name &Health Care Facility: _____

Fax Number/Address: _____

☐ I authorize ***Onsite Employee Health & Wellness*** to request my medical records from:

Provider's Name &Health Care Facility: _____

Fax Number/Address: _____

THIS AUTHORIZATION APPLIES TO THE FOLLOWING INFORMATION:

☐ Entire medical record ☐ Lab Records ☐ Imaging Results ☐ Immunizations

☐ Other: _____

If you DO NOT WANT certain portions of your medical records released, please read this section carefully and initial the boxes for information you do not want released. Otherwise, your records will be released as specified above.

*I authorize the above-named health care provider and its physicians, employees and agents to release the information specified to the organization, agency, or individual named on this request with the exception of:

Initials:
_____ Substance abuse, if any
_____ Psychological/psychiatric conditions, if any
_____ AIDS/HIV/STD's, if any

THE PURPOSE OF THIS RELEASE IS FOR:

☐ Relocation ☐ Changing Insurance ☐ Primary Care Provider Update ☐ Changing Primary Care Providers

This authorization will expire on the following date or upon the occurrence of the following event: _____

*I understand that I may revoke the Authorization at any time prior to the expiration date or event, but that my revocation will not have any effect on actions taken by the above-mentioned health care provider or its physicians, employees, or agents before they receive my revocation. Should I desire to revoke this Authorization, I must send written notice to the above-named health care provider.

*I understand that my records may be subject to disclosure by the recipient and may no longer be protected by federal privacy regulations. I understand that this Authorization does not limit the above-named health care provider's or its physicians', employees' or agents' ability to use or disclose my information for treatment, payment, or health care operations, or as otherwise permitted by law.

_____

Patient or Authorized Representative's Signature *Relationship to Patient* *Date*

_____

(Witness) *Date*
Onsite Employee Health and Wellness Representative