AUTHORIZATION TO RELEASE INFORMATON

Patient's Name: ______________________________
Patient's Address: ______________________________

City, State, Zip: ______________________________
Date of Birth: __________ Telephone #: _______________
SS#: ____

Alan F. Shikoh, M.D.,
721 Glenwood Drive
Suite W473
Chattanooga, TN 37404
Phone: 423/495-4730
Fax: 423/495-4733

I hereby authorize the use or disclosure of my health information as described below. I understand the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by federal privacy regulations.

I authorize Alan F. Shikoh, M.D., P.C. to release copies of my records as listed below. Send the information to:

____
Name of Physician or institution, etc.

____
Address
____
City, State, Zip
____
Telephone Number Fax Number

I authorize the release of information from:

____
Name of Physician or institution, etc.

____
Address
____
City, State, Zip
____
Telephone Number Fax number
Please send information requested to the above address or fax.

Specific description of information (Including dates):
____
____
____
____

Purpose of Release:
____
____
____
____

Changing your mind about this Authorization

I understand that I may revoke this authorization at any time by giving written notice to the Privacy Officer at your office. However, I understand that I may not revoke this authorization for any actions taken before receipt of my written notice to revoke the authorization. In addition, I understand that if I am giving this authorization as a condition of obtaining insurance coverage and I revoke this authorization, the insurance company has a right to contest my claim under the insurance policy.

Expiration date of expressed authorization is ______________. If the patient does not express a desire for a specific date or condition to revoke their authorization it will be a permanent authorization until this office obtains a written request to revoke.
Patient's Initials _______________

Signing this Authorization is not a condition of treatment

I understand that under most circumstances a healthcare provider may not condition treatment, payment, enrollment or eligibility for benefits on my signing this authorization. However, I understand that signing an authorization that permits the use and/or disclosure of my PHI for research purposes may be a condition of my treatment if I am undergoing research-related treatment. Also I may be required to sign an authorization if my treatment is provided solely for the purpose of creating PHI for disclosure to a third party. And under some circumstances, a health plan may condition my enrollment in a health plan or my eligibility for benefits on my providing an authorization permitting the health plan to make enrollment and eligibility determinations.
Patient's initials______________

<u>Individual Patient's Signature</u>

I have had the chance to read and think about the content of this authorization form and I agree with all statements made in the authorization. I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of the PHI described in this form with the staff and/or organizations named in this form.

____

Signature of Patient or Appropriate Legal Representative   Date

____

Print Name of Patient Representative   Relationship to the patient

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their Protected Health Information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of