ESSENTIAL HEALTH ACCESS, P.A.
AUTHORIZATION TO RELEASE HEALTH INFORMATION

PATIENT'S NAME: ____
DATE OF BIRTH: __________________________ SOCIAL SECURITY # ______ - ____ - ______

RELEASE OF INFORMATION **TO** ESSENTIAL HEALTH ACCESS, P.A.
I AUTHORIZE THE RELEASE OF INFORMATION FROM:

NAME OF PHYSICIAN, INSTITUTION, ETC. ____

ADDRESS: ____

PLEASE SEND THE REQUESTED INFORMATION TO:

ESSENTIAL HEALTH ACCESS, P.A.
11826 Kingston Pike, ste 130
Farragut, TN 37934
PH (865) 441-4883 FAX (865) 675-4777

RELEASE INFORMATION **FROM** ESSENTIAL HEALTH ACCESS, P.A.
I AUTHORIZE ESSENTIAL HEALTH ACCESS, P.A. TO RELEASE COPIES OF MY RECORDS AS LISTED BELOW.
THE INFORMATION SHOULD BE SENT TO:

NAME OF PHYSICIAN, INSTITUTION, SELF, ETC ____

ADDRESS: ____

TELEPHONE # __________________________ FAX # ________________________________

DATES OF TREATMENT REQUESTED:

____
(THE INFORMATION THAT IS TO BE RELEASED SHOULD BE DETAILED TO SPECIFIC DATES OF SERVICE, TREATMENT, ETC. A MEANINGFUL DESCRIPTION OF THE INFORMATION TO BE DISCLOSED SHOULD BE PROVIDED.)

CHECK ALL THAT APPLY:
____DISCHARGE SUMMARY
____HISTORY AND PHYSICAL
____OPERATIVE REPORT
____RADIOLOGY
____ER REPORTS
____PHYSICIAN ORDERS / NOTES
____EKG
____LAB
____OTHER________________________
____
____
____

PURPOSE OF RELEASE:
____CONTINUATION OF CARE
____ATTORNEY
____SOCIAL SECURITY
____WORKMAN'S COMPENSATION
____DISABILITY
____INSURANCE
____DEPOSITION
____BILLING
____OTHER______________________________
____
____
____

EXPIRATION: EXPIRATION DATE FOR EXPRESSED AUTHORIZATION IS ______________________, IF THE PATIENT DOES NOT EXPRESS A DESIRE FOR A SPECIFIC DATE OR CONDITION TO REVOKE THEIR AUTHORIZATION, THIS AUTHORIZATION WILL EXPIRE ONE (1) YEAR FROM THE DATE SIGNED BY THE PATIENT OR LEGAL AUTHORIZED AGENT.

REDISCLOSURE: I understand that the information used and/or disclosed according to this authorization may no longer be protected by Federal Privacy Law (also known as HIPPA) and the recipient of you health information may potentially re-disclose it. However, under the Federal Substance Abuse Confidentiality Requirements, 42 CFR Part 2, the recipient may be prohibited from disclosing identifiable substance abuse information.

REVOCATION: I have read, or have had read to me, the above statement, and understand them as they apply to me. I further understand that I may revoke this authorization at any time, except to the extent that action has already been taken in accord with this authorization. Revocation by the ESSENTIAL HEALTH ACCESS. P.A.

patients or legal representative is allowable only in the event that release of information has not already occurred. Specific exceptions to revoke an authorization exist. As detailed by federal law, such as:

ESSENTIAL HEALTH ACCESS, P.A. has taken in reliance thereon, or
The authorization was obtained as a condition of obtaining insurance coverage, whereby another law to contest
Claim under the policy.

In order to revoke an authorization, a written document stating the intent of the patient to revoke such authorization must be either presented in person to or delivered by certified mail to the patient or patient's legal representative and that signature must be formally certified by a Notary Public. I understand that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization.

____ ____________________

SIGNATURE OF PATIENT OR APPROPRIATE LEGAL REPRESENTATIVE DATE

(IF A PERSONAL REPRESENTATIVE OF THE INDIVIDUAL SIGNS THE AUTHORIZATION, A DESCRIPTION OF SUCH REPRESENTATIVE'S AUTHORITY TO ACT ON BEHALF OF THE INDIVIDUAL MUST BE PROVIDED.)

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RELATIONSHIP, IF NOT THE PATIENT

____ ____________________

WITNESS DATE