TRI STAR MEDICAL GROUP
Hermitage Primary Care

5653 Frist Blvd., Ste. 236, Hermitage, TN 37076 ph: 615-232-8812 fax: 615-232-8815

Section A: Required for all Authorizations for Release of PHI or Right to Access

Patient Name:	**Patient's Birth Date:** **Social Security No. (Optional)**
Patient Address:	**Patient Phone Number:**
Sending Provider's Name:	**Sending Provider's Address:** **Sending Provider's Phone#** **Fax#**
Recipient Name: *Hermitage Primary Care, LLC*	**Recipient's Address:** **5653 Frist Blvd., Suite 236, Hermitage, TN 37076**
	Recipient's Phone # 615-232-8812 **Fax# 615-232-8815**

This authorization will expire on the following: (Fill in the Date or the Event, but not both.)

Date: **Event:** **Expires 1 year from signature date**

Purpose of Disclosure:

Description of information to be used or disclosed

Is this request for psychotherapy notes?

☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below.

☐ No, then you may check as many items below as you need.

Description:	*Date(s)*	*Description:*	*Date(s)*	*Description:*	*Date(s)*
☐ All PHI in record ☐ History and Physical ☐ Consult Report ☐ Operative Report ☐ Progress Notes		☐ Physician Orders ☐ Laboratory ☐ Imaging/Radiology ☐ Nursing Notes ☐ Medication Record		☐ Demographics ☐ Rehabilitation Services ☐ Special Test/Therapy ☐ Itemized Bill/Claims ☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial)

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
5. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
6. I will receive a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing?

If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information?

☐ Yes ☐ No

If yes, describe:

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Guardian/Patient Representative:	Date:
Print Name of Patient's Representative:	Relationship to Patient: