AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPPA

256 Seaboard Lane Suite E 102, Franklin, TN 37067

AUTHORIZATION FOR RELEASE AND DISLOSURE OF INDIVIDULALLY IDENTIFIABLE HEALTH INFORMATION BY: SHARA SMILE

I, ____, date of birth__________________________, or my authorized representative, authorizes SHARA SMILE to disclose my health information as described in this Authorization to:
NAME:____
ADDRESS:____
PHONE NUMBER:_________________________________ EMAIL:____

1(a) Specific Information to be released:
I authorize SHARA SMILE to use or disclose the following types of information:
____________ Medical records from (date)______________ to (date)______________________.

____________ Entire Medical Record, including patient histories, clinical documentation (except psychotherapy notes), test results, referrals, consults, billing records, insurance records, and other records.

___________ All records relating to claims submitted and payments made.

___________ OTHER: ____

1(b) Special categories of Information to be released:
This Authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV/AIDS RELATED INFORMATION only if I initial the appropriate line below in this section 1(b). If the health information described in Section 1(a) includes any of these types of information, and I initial the appropriate line in this section 1(b), I specifically authorized the release of such information to the person(s) indicated above.

Include: (indicate my initialing)
_______ Mental Health Information
_______HIV/AIDS Related Information
_______ Alcohol/Drug Treatment

The information is being used and/or disclosed for the following purposes:

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I understand that this Authorization expires when I am not longer a patient of Shara Smile. I understand that after that date, no more of this information can be used or released to the person or organization unless I sign a new Authorization. I understand that I can revoke this Authorization at any time by submitting a written request to SHARA SMILE at the address identified above. I understand that a revocation is not effective to the extent that action has already been taken based on this Authorization. I understand that signing this Authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon signing this Authorization. I understand that I have the right to receive a copy of this Authorization. I understand that this information might be re-disclosed and will no longer be protected by the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations.

Signature of Patient or Personal Representative____ Date: ____________________

Name of Patient or Personal Representative____ Date:____________________

Description of Personal Representative's Authority to Sign for Patient (attach Documents that show authority):
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