□ Pickup □ Mail □ Fax (other providers ONLY) □ File only

Authorization to Use and Disclose Protected Health Information

The purpose of this Authorization is to permit us to use and disclose all or some of your health information, as you specify, for the limited purposes you describe. We are otherwise required by federal law to maintain the privacy of your health information as described in our Notice of Privacy Practices. Your ability to receive treatment, payment, enrollment in a plan, or eligibility for a benefit normally does not depend on your signing this form. **You may refuse to sign this form.** However, we must have your signature in order to disclose your protected health information to anyone you identify below.

Consequences of Signing this Form: Please be aware that if the organization you authorize to receive information is not a health care provider or a health plan, it may redisclose the information without violating federal or state privacy laws.

Revocation: You may revoke this Authorization in writing, at any time, except where we have already relied on it to make a use or disclosure. Your written revocation will become effective once we receive and process it. If you are providing this Authorization to obtain insurance coverage, you may not have the right to revoke it to the extent that it pertains to the insurer's right under the law to contest a claim under your insurance policy. To revoke this Authorization, please send your written request to: Privacy Officer, Semmes-Murphey Clinic, P.C., 6325 Humphreys Boulevard, Memphis, Tennessee 38120.

Patient's full name (*please print*): _____
Address: _____
City: _____ State: _____ Zip: _____
Date of birth: _____/_____ /_____ Patient SSN: XX-XXX- _____

I authorize **Semmes-Murphey Clinic** to use and disclose to:
Recipient's name: _____Relationship to patient: _____
Address: _____
City: _____ State: _____ Zip: _____Phone/Fax #: _____

The following information from my medical record:
□ Complete medical record □ Office notes □ Laboratory results □ CD of images / films
□ Other (*specify*) _____

The purpose or need for the information is: _____

Expiration: This Authorization expires on the date you specify below or six months from date signed. Once this Authorization expires, we will no longer use and disclose your health information for the described purposes unless you sign a new Authorization form.

This Authorization expires (*check one*):
□ In six months □ On the following date other than six months: _____ / _____ / _____
□ When the following event occurs: _____

_____ _____
Signature of patient or personal representative* Printed name of patient or personal representative

_____ _____
Date Relationship to patient (if personal representative)

*If Personal Representative, the patient is unable to sign because (check one): □ Minor □ Incompetent
□ Other (explain): _____

For Office Use Only □ All complete □ Proof of I.D. □ Signed copy to patient
Processed by: _____ MRN _____

<u>PLEASE RETURN AUTHORIZATION TO : Semmes-Murphey Clinic, P.C., ATTN: Medical Records, 6325 Humphreys Blvd, Memphis, TN 38120 or fax to (901) 522-2641 ATTN: Medical Records</u>**