East Tennessee Gastroenterology, PLLC | 2404 Chambliss Avenue | Cleveland, TN 37311
Phone 423-339-2000 • Fax 423-339-2043

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.

Patient Name: Date of Birth: Social Security Number:

Address: City, State, Zip:

Telephone Number: Other Number:

Release of Information from ETG	Release of Information to ETG
☐ I authorize ETG to release copies of my records as listed below. The information should be sent to:	☐ I authorize the release of copies of my records as listed below to ETG. The information should be requested from:
Name of Physician, Institution, Self, etc.	Name of Physician, Institution, Self, etc.
Address	Address
City, State, Zip	City, State, Zip
Telephone Number Fax Number	Telephone Number Fax Number

Dates Of Treatment (Which dates of treatment do you need records for?)
Dates:

The information that is released should be detailed to specific dates of service, treatment, etc. A meaningful description of the information to be disclosed should be provided.

INFORMATION TO BE RELEASED	REASON FOR DISCLOSURE
☐ All	☐ Attorney
☐ History and Physical	☐ Social Security
☐ Operative Report	☐ Continuation of Care
☐ X-Ray	☐ Workmen's Compensation
☐ EKG	☐ Disability
☐ Lab	☐ Insurance
☐ Clinical Visits	☐ Deposition
☐ Hospital Records	☐ Billing
☐ Other	☐ Other (Please specify below)

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 ninety days from the date signed by the patient or legal authorized agent. I have read, and or have had read to me, the above statements, 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 patient or legal representation is allowable only in the event that the release of information has not already occurred. Specific expectations to revoke an authorization exist, as detailed by federal law, such as:

- ETG has taken action in reliance thereon or
- The authorization was obtained as a condition of obtaining insurance coverage, whereby another law provides the insurer with the right to contest a 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 privacy office of East Tennessee Gastroenterology, PLLC. This revocation must contain the signature of 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 patient's representative Date

Witness Date

Printed name of patient's representative

Relationship to the patient