Phoenix Health, PLLC
7405 Shallowford Rd, Ste 230
Chattanooga, TN 37421
Ph: 423-208-8099/Fax: 855-305-1008

2021
AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Authorization for Use/Disclosure of Information: I, _____, voluntarily consent to an authorize my health care provider _____ to use or disclose my health information during the term of this Authorization to the recipient(s) that I have identified below.

Recipient: I authorize my health care information to be released to the following recipient(s):

Providers:

___ (Initial) I authorize my health care information and treatment plan to be disclosed among Phoenix Health, PLLC providers including medications and therapy.

Name: Janelle Edmondson – Nurse Practitioner__ Name: Maria Valenca – Nurse Practitioner
Name: Brandon Luedtke – Physician's Assistant_ Name: Ahmed Ibrahim – Supervising MD
Name: Angela Stutz - Nurse Practitioner_____ Name:_____
Name: Doug Kinnard - Counseling_____ Name: _____
Name: Anna Kate Needham - Counseling_____ Name:_____

Health/Medical Insurance:

Primary Insurance Name:_____Member/Policy ID:_____
Phone/Address:_____
Secondary Insurance Name:_____Member/Policy ID:_____
Phone/Address:_____

Pharmacy:

Name:_____Phone/Address:_____
Name:_____Phone/Address:_____

Family Members/Emergency Contact:

Name:_____Phone/Address:_____
□ Please circle: Appointment reminders/health status/treatment plan/_____.
Name:_____Phone/Address:_____
□ Please circle: Appointment reminders/health status/treatment plan/_____.
Name:_____Phone/Address:_____
□ Please circle: Appointment reminders/health status/treatment plan/_____.

Purpose: Authorization for release of medical information is at the request of the patient.

Information to be disclosed: I authorize the release of the following health information: (check the applicable box below)

- ❑ All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition, drug and/or alcohol conditions, and any treatment received by me.

- ❑ Only the following records or types of health information:_____.

- ❑ I authorize voicemails may be left from office staff including but not limited to appointment reminders, well-calls, treatment specific information including medications.

- ❑ I authorize text messages may be sent for appointment reminders.

Term: I understand that this Authorization will remain in effect:
- ❑ From the date of this Authorization until the _____ day of _____, 20___.
- ❑ Until the Provider fulfills this request.
- ❑ Until the following event occurs:_____

Redisclosure: I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke: I understand that signing this form is voluntary and that if I don't sign, it will not affect the commencement, continuation or quality of my treatment at Phoenix Health, PLLC; however, not signing may inhibit continuity of care. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

_____ _____ _____
Signature Date Signature of Witness

If Individual is unable to sign this Authorization, please complete the information below:

_____ _____ _____ _____
Name of Guardian/ Representative Legal Relationship Date Witness