HIPAA AUTHORIZATION FORM

I authorize Dr. Carl E Flinn to use and disclose my protected health information (PHI) listed below for the purpose(s) listed elsewhere on the page.

Patient: _____ DOB: _____

Records from:

_____

_____

_____

Records to:

Dr. Carl Flinn

773 Estate Place, Memphis, TN 38120

901-681-4040 (p) 901-681-4052 (f)

Describe how the PHI will be used or disclosed, such as the date of service, type of service, level of detail to be released, origin of information, etc.

** We are requesting all pertinent office notes, surgery notes, test results, etc for the above patient from _____(date) to _____(date).

This PHI is being used or disclosed for the following purposes: (List specific purposes here)

** All requested records will be read and reviewed by _____ (Dr/Clinic name) for the purpose of treating the above patient. Records will then be placed in the patient's chart for future reference.

This authorization shall be in force and effect until _____ (specify date), at which time this authorization to use and disclose this PHI information expires.

I understand that I have to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Officer at 773 Estate Place, Memphis, TN 38120. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the PHI or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. The use or disclosure requested under this authorization may result in direct or indirect remuneration to the physician from a third party.

_____ _____

Signature of Patient or Personal Representative Date

_____

Print Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority