The Journey Center for Healing Arts, PLLC

2700 South Roan Street, Suite 410 Johnson City, TN 37601 P: 423.408.8041 F: 844.400.3966

Patient Authorization for Release of Health Records to External Parties

1. I,____(*patient*) Birthdate:________________

authorize my health care information be released to/from:

____

____

____

2. **The information is to be disclosed to/from**:

The Journey Center for Healing Arts, PLLC

2700 South Roan Street, Suite 410 Johnson City, TN 37601

Phone: 423.408.8041 Fax: 844.400.3966

I authorize this information to be disclosed in the following ways:

- ❑ Written/Photocopy/Paper ❑ Electronic Format ❑ Verbal ❑ Fax ❑ Electronic Mail *

Purpose of the disclosure: ____

3. **Dates of Treatment:** From: ______________________________ To: ______________________________

Specific reports to be disclosed:

- ❑ Progress Notes, Assessments and Treatment Plans
- ❑ Audio/Videotapes
- ❑ Entire Health Records (including, but not limited to, information regarding medical/health treatment, insurance, demographics, referral documents, and records from other facilities.)
- ❑ Other (Specify):____

I give specific authorization to disclose the following information:

- ❑ HIV test results
- ❑ Documentation of AIDS diagnosis
- ❑ Drug and alcohol abuse treatment records
- ❑ Psychiatric/Mental Health treatment records

I understand that I may withdraw or revoke my permission at any time. If I withdraw my permission, my information may no longer be used or released for the reasons covered by this authorization. However, any disclosures already made with my permission are unable to be taken back. I may revoke this authorization by notifying The Journey Center for Healing Arts, PLLC in writing.

My treatment will not be based on the completion of this authorization form. The information to be released by this authorization may be re-released by the person or organization that receives it and may no longer be protected by Federal or state privacy regulations.

Unless revoked earlier, this authorization expires in one year unless I specify another time: ________________________

I release the individual and organization named in this authorization from legal responsibility or liability for the disclosure of the records as authorized on this form. I understand that this authorization is voluntary and that I may refuse to sign it. I will be provided a copy of this signed authorization, if requested. A photocopy of this authorization is as valid as the original.

____ ____

Signature of Patient (or Patient Representative) Date

____ ____

Printed Name of Patient or Patient Representative Authority of Representative to Act for Patient (Relationship to Patient)