Cumberland Family Care, PC
457 Vista Drive + Sparta, TN 38583
Phone (931) 738-3383 + Fax (931) 738-8911

Authorization of Disclosure of Protected Health Information by Another Covered Entity for Use by Cumberland Family Care, PC

Information to Be Used or Disclosed

Information to be obtained under this authorization includes:

_____

- I understand that this Information my Include any history of acquired Immunodeficiency syndrome (AIDS); sexually transmitted diseases; human Immunodeficiency virus (HIV) Infection; behavioral health service/psychiatric care; treatment of alcohol and or drug abuse; or similar conditions.
- I understand that I may request certain Information ***not*** be released, even If occuring during the dates above. (Please specify Information you do not want released)_____
  _____
- I understand that Information that Is disclosed under this authorization may be disclosed again by the person or organization to whichh It Is sent. It may not be possible to ensure your right to the protection of the privacy of this Information once Cumberland Family Care, PC discloses It to another party.

Purpose of Disclosure

Information listed above will be disclosed for the following purposes:

_____

Persons Authorized to Use or Disclose Information

_____
Name of person/organization/entity providing requested information

Persons to Whom Information May Be Disclosed

Cumberland Family Care, PC
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Expiration Date of Authorization

This authorization is effective through ___/___/___ unless revoked or terminated by the patient or patient's personal representative.

Potential for Re-disclosure

Information that is disclosed under this authorization may be re-disclosed. The privacy of this information may not be protected under the Federal privacy regulations.

Rights of the Individual

- You may Inspect or copy Information used or disclosed under this authorization.
- You may refuse to sign this authorization.
- You may revoke or terminate this authorization by submitting a written revocation to Cumberland Family Care, PC, and it will be effective on the date notified except that action has already been taken in reliance upon it.

Signature

Name of Patient (Print or Type) _____

Address: _____

Signature of Patient _____

Date _____

Date of Birth _____ SSN: _____
Signature of Patient Representative _____

Relationship of Patient Representative to Patient _____

Witness Signature _____
Date _____