THE CONRAD | PEARSON CLINIC

1325 Wolf Park Drive
Germantown, TN 38138

AUTHORIZATION TO DISCLOSE INFORMATION

For additional information about how your medical information may be used or disclosed, please see the Patient Notice.

YOU MAY REFUSE TO SIGN THIS FORM, HOWEVER IT MAY PREVENT US FROM COMPLETING A TASK YOU HAVE REQUESTED (such as examining you to create a report for your attorney)
WE WILL NOT CONDITION YOUR TREATMENT ON AN AUTHORIZATION, EXCEPT FOR AN AUTHORIZATION FOR RESEARCH-RELATED TREATMENT

THIS AUTHORIZATION IS VOLUNTARY

By my request, I hereby authorize The Conrad Pearson Clinic to disclose information regarding my treatment, insurance issues and payment issues to the people listed below:

Name	Relationship/Phone Number
_____	_____
_____	_____
_____	_____

I understand that this authorization is voluntary. I understand that the person to whom I authorize disclosure of my personal data is not a health plan, health care provider, or clearinghouse and that the released information, in their possession, may no longer be protected by federal privacy regulations. I understand that I may withdraw my authorization in writing to the Privacy Officer of The Conrad Pearson Clinic at any time, except to the extent that action has been taken in reliance on this statement. I understand that even if I do not withdraw authorization that this statement will expire _____ **[need to fill in time, not shorter than 1 year, but could be 5 or 10]** year(s) from this date. I have carefully read and understand the above, and do herein expressly and voluntarily authorize the disclosure of the above information about my condition to those persons or agencies listed above.

_____ _____
Signature of patient or patient's representative Date

Printed name of patient's representative _____
Description of the Representative's authority to act for the patient

_____
Relationship to patient _____