**AUTHORIZATION FOR RELEASE/ REQUEST OF INFORMATION**

Pathways To Wellness

Dr. Kellye Hudson

117 Forest Court

Knoxville, TN 37919

Phone: 865-518-7925

**To:**

**Address:**

**Phone:**

**Fax:**

**Purpose of release:** Continuation of Care Insurance Claim Litigation

Personal Other:

I herby authorize and request you to release to **OR** receive from:

**Pathways To Wellness**

Protected/Sensitive Health Information to be disclosed below:

Discharge Summary

History/ Physical

ED Visit

Progress Notes

Lab Reports

Medication

Billing Information

Entire Medical Record

Other:

* I understand that I have a right to revoke this authorization in writing at any time by notifying Pathways To Wellness.
* I understand that stopping this authorization would not apply to information that has already been released or disclosed.
* I understand that authorizing the release of this health information is voluntary. I can refuse to sign this authorization.
* I understand that I may inspect or copy the information to be used or disclosed.
* I understand that any disclosure of information carries with it the potential for re-disclosure and information may not be protected by federal or state privacy laws/rules.

**This authorization will end one year from the date the form is signed unless I indicate an earlier date or event here:**

**Name of Patient (Print):**

**Patient/Guardian Signature:**

**Date:**

***February 2022***