Simply Better Medicine

Dr. Meghan Sills
3011 Harrah Drive Suite N
Spring Hill, TN 37174

Authorization to Release Protected Health Information

Patient's Name:_____ Birth Date:_____ Last 4 digits of S.S. #_____

Address: _____ Phone #: _____

I authorize:
Clinic name: _____
Address: _____ Phone #: _____

To release my information to: **Simply Better Medicine**

Dr. Meghan Sills
3011 Harrah Drive Suite N Spring Hill, TN 37174

info@simplybettermed.com
(931) 538-3105 (office) (931) 538-3062 (fax)

PURPOSE: _____Further Care _____Personal Use

Date(s) of treatment to be released: _____to:_____

Information to be released: _____ Office/Clinic Notes _____ Lab reports
_____ Imaging Reports _____ Immunizations
_____ ALL RECORDS

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION:

I understand that my records may include information regarding the diagnosis or I understand that:

- I do not have to sign this authorization in order to receive treatment, payment or eligibility of benefits.
- the release of my information may include information regarding diagnosis and/or treatment from other facilities or providers.
- this authorization will remain in effect for ninety (90) days after the date recorded below.
- this authorization can be taken back (revoked) at any time with a written request to the office named above.
- revoking the authorization stops further release but cannot undo any release of information that may have already occurred
- once the information is released because of this request, it could be released by the recipient and the information may not be protected by Federal privacy regulations.

I also understand that my records may include information regarding tthe diagnosis or treatment for alcohol and/or drug abuse, psychiatric or mental illness; and/or sexually transmitted diseases (STDs), as well as AIDS or HIV information AND that I can limit the release of this information.

My signature below authorizes SBM to furnish or obtain the information specified above even though the confidentiality of the information may be protected by Federal and State law and regulations.

SBM is hereby released and discharged of any liability, and I will hold SBM harmless for complying with this authorization

_____ _____ _____

Printed Name of Patient/Authorized Individual Signature of Patient /Authorized Individual Date

_____

Relationship to patient
(If the above signature is not that of the patient, please explain why. Documentary evidence of guardianship may be required to accompany this form.)