HENLEY MEDICAL

AUTHORIZATION TO RELEASE/OBTAIN MEDICAL RECORDS INFORMATION

With my consent, Henley Medical may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Henley Medical's Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. Henley Medical reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Henley Medical's Privacy Officer at 1090 McCallie Avenue, Chattanooga, TN 37404. With my consent, Henley Medical may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my care. With my consent, Henley Medical may mail to my home or other designated location any items that assist in carrying out TPO, such as appointment reminders and patient statements as long as they are marked Personal and Confidential. With my consent, Henley Medical may e-mail to my home or other designated location any items that assist in carrying out TPO, such as appointment reminders and patient statements.

Person/Facility to provide records: _____

Patient's Name: _____

Social Security #: _____ DOB: _____

Person/Facility to receive records: Henley Medical Fax #: 423-629-8810

Address: 1090 McCallie Ave

City: Chattanooga State: TN Zip Code: 37404

Release the following records: **Initials**

1. Only records and photographs generated by this facility _____
2. Only a portion of records maintained at this facility (*Please specify dates of treatment, etc. below) _____
3. All medical records and photographs at this facility _____

If you do not want certain portions of your medical records released, please read this section carefully and initial the boxes for information you do not want released. Otherwise, your records will be release as specified above.

I authorize the health care provider to release the minimum necessary information specified to the organization, agency, or individual names on this request with the EXCEPTION of:

Initials Initials

_____ Substance abuse, if any _____ AIDS/HIV, if any

_____ Psychological or psychiatric conditions, if any

Other (Please specify) _____

Henley Medical is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

Expiration or revocation of authorization: I understand that I may revoke my consent in writing except to the extent that Henley Medical has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Henley Medical may decline to provide treatment to me.

By signing this form, I am consenting to Henley Medical's use and disclosure of my personal health information to carry out treatment, payment and healthcare operations.

Authorized signature: _____ Date: _____

Relationship to patient: _____

REVISED 4/2004