CHARIS HEALTH CENTER
AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize the Charis Health Center to release my protected health information, if necessary, to the people named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

I understand that Charis Health Center may need to discuss my medical condition and may need to share my medical records with any physician, physician extender, nurse, therapist, or other health care provider who is involved in my care.

	Yes	No
Charis has my **consent to call** for appointment reminders on my cell phone, home phone or answering machine	☐	☐
Charis has my **consent to text** upcoming appointment reminders to my cell phone	☐	☐
Charis may leave messages for appointment reminders with others in my home.	☐	☐
I give Charis permission to talk with the person(s) listed below about my medical condition and/or test results	☐	☐

Name _____ Phone Number _____

Name _____ Phone Number _____

Signature _____ Print Name _____ Date_____

CONSENT TO TREAT

I hereby voluntarily consent to medical examinations, treatment and procedures which are deemed necessary in the opinion of my health care providers, including HIV tests, laboratory tests, and x-rays.

I understand that my medical information is strictly confidential and is protected by Tennessee law and no guarantees or warrantees have been made to me concerning the results of the examination, treatments or procedures.

My signature acknowledges that I have been given the opportunity to ask questions about this consent form and that I have the ability to refuse services.

Signature _____ **Date** _____

RIGHTS OF THE PATIENT

I understand that I have the right to change this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed in this document by sending written notification to:
Clinic Director, Charis Health Center, 2620 N. Mt. Juliet Road, Mt. Juliet, TN 37122

I understand any change in this authorization is effective from the date signed going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse this authorization and that my treatment will not be conditioned upon signing. This authorization shall be in effect until revoked by the patient.

Signature _____ **Date** _____