MIDSTATE PULMONARY | Advanced HEALTH

Authorization To Release Medical Information/Media Release Form

Patient Name: _____

Address: _____ City: _____

State: _____ Zip: _____ DOB: _____ Age: _____ Phone: _____ Cell: _____

email: _____

AUTHORIZATION IS GIVEN BY THE UNDERSIGNED TO RELEASE THE INFORMATION SPECIFIED BELOW:

FROM	**Name of Organization or Person to RELEASE information:** MidState Pulmonary, 300 20th Avenue North, Suite G4, Nashville, TN 37203
TO	• Individuals involved in training at MidState Pulmonary • The media, including but not limited to, newspapers, television, radio, and other print or electronic media outlets (the "Media") • The general public for use in marketing materials of MidState Pulmonary

THE INFORMATION IS REQUESTED FOR THE FOLLOWING PURPOSE:

☐ Training materials ☐ Communicating with the Media ☐ Marketing of MidState Pulmonary

☐ Other (Specify) _____

I understand that this authorization can be revoked by me at any time by submitting a written request to:
MidState Pulmonary, 300 20th Avenue North, Suite G4, Nashville, TN 37203

I understand that revocation will not apply if MidState Pulmonary has already released my information.

I understand that MidState Pulmonary cannot require me to sign this authorization as a condition for providing treatment or obtaining payment for same.

I understand that the material released as a result of this authorization may be subject to redisclosure and no longer protected by the laws applying to medical information release.

This authorization will expire as follows: _____

INFORMATION TO BE RELEASED:

Dates of treatment: _____

Type of treatment: ☐ Emergency Room ☐ Inpatient ☐ Outpatient

☐ Name, treatment location, and condition treated
☐ Specific details and outcomes of treatment provided
☐ Testimonial statement or interview
☐ Photographic or video graphic image or likeness

The undersigned also hereby transfers and grants to MidState Pulmonary the exclusive right to use and authorize others to use all or any part of my (his/her) interview/ photograph/videograph in related media such as books, magazines, journals, pamphlets, electronic, and other written and video formats. The undersigned also hereby releases MidState Pulmonary and its directors, its members, trustees, officers, employees and agents, from any and all claims, demands, causes of action and suits, including, but not limited to, claims for invasion of privacy, defamation, breach of contract, or other breach of duty arising out of or in connection with the use of this interview, photograph or video.

_____ _____
Signature of Patient Date Signed

_____ _____
Signature of Other Authorized Person Relationship to Patient

Authorization must be signed by the parent or legal guardian of any patient under 18, the legal guardian of any patient under guardianship. If patient is under 18 and records are protected by Federal Law (42 CFR Part 2) regarding drug and alcohol abuse, authorization must be signed by both patient and parent or legal guardian. Emancipated minors may sign for self.

PEACOCK ▪ CARPENTER ▪ CAPIZZI ▪ TYSON ▪ PRITCHETT ▪ ATWATER ▪ PHILLIPS ▪ FERRELL ▪ BURK ▪ KHA
300 20th Avenue North ▪ Suite G4 ▪ Nashville, TN 37203 ▪ 615.284.5098 ▪ fax: 615.284.5385 ▪ www.midstatepulmonary.com