TENNESSEE FAMILY MEDICINE

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Authorization to Release Patient Information

Patient Name _____ Date of Birth _____

Address _____ Phone _____

City _____ State _____ Zip _____

Person to SEND Medical Information:	***Person to RECEIVE Medical Information:***
Name _____	Name _____
Address _____	Address _____
City _____ State _____ Zip _____	City _____ State _____ Zip _____
Phone _____ Fax _____	Phone _____ Fax _____

Information to be Released		**Purpose for Disclosure**	
___ Entire Record	___ Lab/Pathology Reports	___ Changing MD/Continued Care	
___ Imaging Reports	___ History & Physical	___ Disability	___ Legal/Attorney
___ Consultation Reports	___ Other _____	___ Insurance	___ Other

Dates of Treatment (dates of treatment you need records for)

From _____ To _____

I acknowledge, and hereby consent to such, that the released information may contain substance abuse, HIV / AIDS information and mental health issues (not including Psychotherapy notes).

Revocation I understand that I may revoke this authorization at any time by sending a written notice to Tennessee Family Medicine. However, the revocation will not have any effect on any uses or disclosures Tennessee Family

Medicine may have made before the revocation was received.

Expiration I understand that unless I revoke this authorization earlier, this authorization will automatically expire twelve (12) months after the date this authorization is signed.

Redisclosure I understand that information used or disclosed in accordance with this authorization may no longer be protected by federal law, and could by redisclosed by the receiving party.

Refusal to Sign I understand authorizing the use or disclosure of information is voluntary. I do not have to sign to ensure treatment.

I understand I get a copy after I sign it.

_____ _____ _____

Signature of Patient /Authorized Person | Relationship to Patient (if applicable) | Date