TENNESSEE
FAMILY MEDICINE

1047 Glenbrook Way Suite 120
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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(All sections must be completed)

Patient Name: _____Date of Birth: _____
Address: _____
Phone: _____ SSN: _____

I authorize: (enter your current physician's information)
Name:_____
Street:_____
City: _____State:_____Zip:_____
Phone: _____ Fax: _____

To release copies of my medical records to : (enter where you want records released to)
Name:_____
Street:_____
City: _____State:_____Zip:_____
Phone: _____ Fax: _____

I authorize release of information of the following portions of my medical record:
____Entire Medical Record ____Office Notes ____Lab Reports
_ _Radiology Reports ____Notes from Specialists ____Immunizations
____Other (please specify) _____

The authorization will expire on: _____
(Date or Event may not exceed one year)

If you DO NOT WANT certain portions of your medical records released, please initial the box for the information you do not want released.

_____Substance abuse _____ Psychological or psychiatric treatment ____HIV/AIDS/STD

I understand I have a right to revoke this authorization by written notification to the Privacy Officer. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure which may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization. I understand that I can refuse to sign this authorization and the above-named office may not condition treatment on my signing of this authorization.

_____ _____
Signature of Patient or Authorized Representative Date