Medina Family Medical Clinic
209 Grace Cove, PO Box 100
Medina TN 38355

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION FROM ANOTHER FACILITY

Patient Name: _____

Date of Birth: _____

Social Security Number: _____

Release Records To:

Clinic:	Medina Family Medical Clinic	**Address:**	PO Box 100, 209 Grace Cove		
City:	Medina	**State:**	TN	**Zip:**	38355
Phone Number:	(731) 783-0400	**Fax Number:**	(731) 783-0402		

Person / Organization Authorized to Disclose Protected Health Information:

Clinic: _____

Address _____ **City:** _____ **State:** _____

Phone #: _____ **Fax #:** _____

Choose From the Following:

_____	Entire Chart	_____	Radiology Reports	_____	History & Physical
_____	ER Record	_____	Consultation	_____	Immunization(s)
_____	Operative / Procedure Report	_____	Discharge Summary	_____	Other: _____
_____	Lab(s)				*specify*

I understand that:

1. I may revoke this authorization in writing at any time by notifying the person/organization providing or disclosing the information (releasing facility). However, if I revoke this authorization, it will not have any effect on any actions taken by the person/organization providing, disclosing or receiving the information prior to receiving the revocation. Nor shall it be valid to the extent that the disclosing person/organization or receiving organization has taken action in reliance on this authorization.
2. This authorization allows the facility to which records are being released (hereafter referred to as the receving facility) to obtain any and all documents in my medical record including those copies from other health care facilities and providers. I understand that the information that is released or provided may be re-disclosed and no longer protected by federal privacy regulations.
3. Any disclosure of records concerning diagnosis and/or treatment of alcohol and/or drug abuse is covered by Title 42 CFR, and if there is any such information, I hereby authorize the release of information. This authorization also includes any information related to diagnosis and/or treatment of any psychiatric or mental illness or any state of infection with the HIV (AIDS) virus.
4. The receiving facility is hereby released from any liability and the undersigned will hold the receiving facility harmless for requesting or seeking my protected health information.
5. I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal will affect my ability to obtain treatment, receive payment or eligibility for benefits.
6. The authorization will expire in ninety (90) days unless I provide an alternate date or event. This authorization will not apply to any dates of service that occur after the date this authorization is signed.
7. A facsimile of this authorization or a copy of this authorization shall be valid and binding with the same force as an original signature and the person/organization releasing the information shall be entitled to rely on the same.

I have read and understand this authorization. I hereby authorize the release of the above-requested medical information about me to the receiving facility from the releasing facility named above.

_____ _____
Signature of Patient Date

_____ _____
Signature of Patient's Authorized Representative Description of Representative's Authority to Act for Patient

_____
Telephone Number

The purpose of this disclosure is for continuation of medical care.