Medina Family Medical Clinic
Authorization for Release of Protected Health Information

Patient Name: _____
Date of Birth: _____
Social Security Number: _____

Release Record To:
Medina Family Medical Clinic
209 Grace Cove – PO Box 100
Medina, TN 38355
Phone: 731-783-0400 Fax: 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 Records	____Consultation	____Immunization(s)
____Operative/Procedure Report	____Discharge Summary	____Lab(s)

____Other (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.
2. This authorization allows the facility to which records are being released to obtain all documents in my medical record. I understand that the information this 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 also includes any information related to the diagnosis/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 with hold the receiving facility harmless for requesting or seeking my protected health information.
5. I understand 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.
6. This authorization will expire in 90 days unless I provide an alternative 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 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

_____ _____

Signature of Patient's Authorized Representative Representative's Authority

_____

Phone Number