TENNESSEE MATERNAL FETAL MEDICINE, PLC

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION:

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____/_____/_____ SS#: _____-_____-_____ Phone#: _____-_____

Mailing Address: _____ Apt#: _____

City: _____ ST: _____ Zip: _____

I AUTHORIZE MEDICAL RECORD INFORMATION TO BE RELEASED FROM:

Practice/Physician Name: _____

Address: _____

City: _____ ST: _____ Zip: _____

Phone#: _____ Fax# _____

AND DISCLOSED TO:

Practice/Physician Name: _____

Address: _____

City: _____ ST: _____ Zip: _____

Phone#: _____ Fax# _____

Information to be released:

☐ Complete Copy of All Records
☐ Lab Reports
☐ Telephone/Verbal Communication Records
☐ Counseling/Consultation Visits
☐ Ultrasonography Reports
☐ Operative/Procedure Reports
☐ Other _____

FOR THE FOLLOWING DATES: _____

PURPOSE OR NEED FOR DISCLOSURE:

☐ Personal ☐ Continuing Medical Care ☐ Insurance ☐ Legal ☐ Academics ☐ Other _____

EXPIRATION DATE:

This authorization will remain in effect until this request is processed unless you specify an additional time period/event.

☐ On this date: ___/___/_____ or After this event/condition: _____

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IMPORTANT NOTICES:

I understand that my medical record information may include information on diagnosis and/or treatment related to psychiatric or psychological conditions, drug and/or alcohol abuse, acquired immune deficiency syndrome (AIDS) and/or HIV status.

I also understand that I have the right to revoke this authorization at any time in writing. I understand that if I want to revoke this authorization I must do so by writing to the person or practice that I have authorized to disclose my medical records. I understand that any revocation will not apply to any medical record information that has already been released in response to this authorization. I understand that if I am giving this authorization as a condition for obtaining insurance coverage and I revoke this authorization, the insurance company has a right to contest my claims under the insurance policy.

I understand that I do not have to sign this authorization to receive treatment.

I understand that once my medical record information is disclosed as I have authorized, it could be re-disclosed by the recipient and may no longer be protected by federal privacy laws.

_____ _____

Signature of Patient or Parent, Legal Guardian or Personal Representative Date

_____ _____

If not patient, state relationship to patient Date