

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:

Reviewed/Released 7/2012

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