OFFICE OF
INTERNAL MEDICINE

1325 Eastmoreland Ave
Suite 425
Memphis, TN 38104
Phone: (901) 726-0843
Fax: (901) 708-2699

Authorization for Release of Confidential Health Information

Individual Information:

______________________ Name
____/____/________ Date of Birth
(______) ______-________ Phone #

______________ Street Address ______ Suite / Apt. ______________ City ______ State ______ Zip

Information may be disclosed by:

______________________ Name of organization or person releasing information

______________ Street Address ______ Suite / Apt. ______________ City ______ State ______ Zip

(______) ______-________ Phone #
(______) ______-________ Fax #

Information may be disclosed to:

______________________ Name of organization or person to receive information

______________ Street Address ______ Suite / Apt. ______________ City ______ State ______ Zip

(______) ______-________ Phone #
(______) ______-________ Fax #

Information to be disclosed:

Choose only ONE option. Copy fees may apply.

- ☐ Information from the most recent 2 years of office visits
- ☐ All information from date: ____/____/________to date: ____/____/ ________
- ☐ Information regarding specific treatment, condition, or other (specify): ______________________

Why are you asking for this health information to be released?

Choose only ONE option. Copy fees may apply.

☐ Attorney ☐ Insurance ☐ Doctor ☐ Medical Leave ☐ Personal ☐ Other:

Authorization: ______________

This authorization expires 60 days from the date signed or on the date or event indicated here:

____

Information released may include any of the following: laboratory reports, x-ray reports, operative notes, and information regarding the testing, diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, chemical dependency, or mental/psychiatric illness. By my signature, I give my specific authorization to be released.

I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the practice. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

______________ Printed Name
______________ Signature
______________ Date Signed

Relationship to Patient: ☐ Self ☐ Parent ☐ Legal Guardian ☐ Power of Attorney