AUTHORIZATION OF RELEASE OF MEDICAL INFORMATION

Patient's Name: _____ **DOB:** _____

Phone #: _____ **SS #:** _____

Address: _____

_____

I authorize records: (please select one)

☐ To be released ***TO*** **Care Memphis Clinic** from _____

Address: _____

Phone: _____ Fax: _____

☐ To be released ***FROM*** **Care Memphis Clinic** to _____

Address: _____

Phone: _____Fax: _____

I request release of the ***complete health record(s)*** for *all* ***dates of service*** unless specified here: _____

_____

_____

The purpose of this disclosure is for ***treatment/payment/healthcare operations*** unless specified here: _____

_____

This authorization gives **Care Memphis Clinic** permission to request your medical records from any health care provider that you have received treatment from as specified above for the duration that you have a direct treatment relationship with **Care Memphis Clinic. Care Memphis Clinic** is authorized to furnish information even though the confidentiality of the information may be protected by Federal or State laws & regulations. **This includes any and all alcohol &/or drug treatment records or psychiatric records and any information related to HIV or sexually transmitted disease testing or results that are in the record, unless otherwise specified above. Care Memphis Clinic** is released and discharged from any liability, and the undersigned will hold **Care Memphis Clinic** harmless for complying with this information. I understand that I am not required to sign this authorization. I understand that I may revoke this authorization at any time by presenting my written revocation to **Care Memphis Clinic**., 493 Dr. M.L. King, Jr. Ave, Memphis, TN 38126. I understand that the revocation will not apply to information that has already been used or released under this authorization. I understand that the medical office has the right under Tennessee state law to require payment up front for reasonable costs of copying and mailing before furnishing the medical records.

_____ _____

Signature of Patient or Legal Representative Printed Name of Patient or Legal Representative

_____ _____

Relationship to patient or Legal Representative Date

_____ _____

Witness Date

NOTICE TO PERSON OR AGENCY RECEIVING THIS INFORMATION: *This information has been disclosed to you from records whose confidentiality is protected. Laws & regulations prohibit you from making further disclosure of it without the specific written consent of the person to whom it pertains. A general authorization for release of medical or other information is not sufficient.*

CARE MEMPHIS CLINIC, PLLC.

www.carememphis.com
901-526-0802

Administration:
493 Dr. M.L. King, Jr, Ave
Memphis, TN 38126
901-526-0802

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

(This form gives permission to share certain patient health information with the people listed below)

By signing, I authorize **Care Memphis Clinic** to use and/or disclose certain protected health information (PHI) about me to the following individuals:

_____
Name Relationship to Patient

_____
Name Relationship to Patient

_____
Name Relationship to Patient

This authorization permits **Care Memphis Clinic** to use and/or disclose protected health information about me (such as dates of services, type of services, lab and test results, prescription information, recommendations of treatment, etc.). The following is excluded from this authorization.

_____

_____

I have the right to refuse to sign this authorization. I do not have to sign this authorization in order to receive treatment from **Care Memphis Clinic**. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

This authorization is in effect until revoked in writing by patient. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at:

Care Memphis Clinic, PLLC
493 Dr. M.L. King, Jr. Ave
Memphis, TN 38126

_____ _____
Signature of Patient or Legal Guardian Relationship to Patient

_____ _____
Print Patient's Name Effective Date

_____
Print Name of Patient or Legal Guardian, if applicable

Signed by: