AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(All sections must be completed)

Diane M. Long, MD
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A. Franklin Kennedy, MD
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Kristal D. Taylor, MD
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Walter A. Ruch Jr., MD, Emeritus
Henry P. Sullivant Jr., MD, Emeritus
John H. Pickens, MD, Emeritus
Walter A. Ruch, MD 1894 - 1958
Bradford W. Kincheloe, MD 1944 - 1996
Robert M. Ruch, MD 1923 - 2008

Patient Name: ____
(First) (Middle Initial) (Last) (Maiden)

DOB:________________________

By signing below, I authorize the below entities (their physicians, employees, and agent(s) to release, obtain or disclose all of my medical records, including any specially protected records, such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia, sexually transmitted diseases or HIV/AIDs infection, unless specifically marked below.

I authorize release of my records <u>from</u>:

Name: ______________________________

Phone: ______________________________

Fax: ______________________________

I authorize release of my records <u>to</u>:

Name: ______________________________

Phone: ______________________________

Fax: ______________________________

Purpose of disclosure: ______________________________

This authorization expires ____________________; or event ____________________
(If no date is given it will expire at the end of 90 days and may not exceed one year.)

The request and authorization applies to:

______ All medical records.

______ Health care information relating to the following treatment, condition, or dates of treatment.

____

______ Specific records to be released (e.g., labs, imaging reports, other)

____

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If you DO NOT want certain portions of your medical records released, please <u>initial</u> the box for the information you DO NOT want released.

____ Substance Abuse ____ Psychological or psychiatric treatment ____ HIV/AIDS/STD

I understand I have a right to revoke this authorization by written notification to the Privacy Officer, except to the extent it has acted in reliance thereon before notice of revocation. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure which may not be protected by Federal confidentiality rules. I understand that I may request a copy of this authorization. I understand that I can refuse to sign this authorization and the above-named office may not condition treatment on my signing of this authorization.

______________________________________ ____________________
Signature of Patient or Authorized Representative Date Signed

____
Relationship to Patient

6215 Humphreys Boulevard
Suite 500
Memphis, TN 38120

901-682-0630

Fax Numbers:
901-682-0635 (med. records)
901-322-6200 (bus. office)

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