Mestemacher Clinic for Women

(a division of Memphis Obstetrics and Gynecological Association, PC)

7918 Wolf River Boulevard; Germantown, TN 38138
901-624-4444 [phone] / 901-202-4920 [fax]

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(Important: All sections MUST be completed.)

Patient:_____ Birth Date:_____

Address:_____ Phone: ( ) _____

_____ SS#: _____

Release From:_____ Release To:_____

_____ _____

_____ _____

Specific type of information to be released: ☐ Any/All Records ☐ Diagnostic Reports ☐ Lab Results

☐ Chart Notes ☐ Consultation Notes ☐ Operative Notes ☐ Other_____

for date range: _____to:_____
(if no time period specified, record from previous 5 years only will be released)

Purpose of disclosure: ☐ Transfer of Care – Reason:_____

☐ Disability ☐ Worker's Comp ☐ Social Security ☐ Insurance

☐ Attorney Request ☐ Other:_____

There is a $20 fee for release of medical records, which will be the responsibility of the patient.

I understand that my medical records may contain information **related to communicable diseases and infection information** as defined by statute and **Department of Public Health Rules** (which include venereal disease "VD," tuberculosis "TB," Hepatitis (any form), Human Immunodeficiency Virus "HIV", Acquired Immunodeficiency Syndrome "AIDS" and AIDS Related Complex "ARC;" **alcohol and/or drug abuse treatment information** protected under regulations in 42 Code of Federal Regulations, Part 2; and **mental health treatment records, psychological services** and/or **Social Services** information including communications made to or by a social worker, psychologist or psychiatrist.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Privacy Officer. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire after one (1) year.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure, and the information may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization. If I have questions about disclosure of my health information, I may contact the Privacy Office at the disclosure location.

_____ _____
Signature of Patient or Legal Representative Date

_____
If Signed by Legal Representative, Relationship to Patient