Christian Family Medicine & Pediatrics

Authorization for Release of Medical Records

Please send a copy of this release with the requested records.

PATIENT INFORMATION (Please print)			
Patient Name	Date of Birth	Social Security Number	
Address	City	Zip	Phone

RELEASE FROM (Name of physician or facility releasing information)

I authorize release of my medical record from

Physician/ Facility			
Address	City	Zip	Phone

RELEASE TO (Name of physician or facility receiving information)

Please send my medical record to:

Physician/ Facility	Christian Family Medicine			
Address 79 Hwy 51 South	City Ripley	Zip 38063	Phone 731-635-8189	Fax 731-635-8126

RELEASE INFORMATION

Reason: ( ) Change of Insurance ( ) Transfer of Care ( ) Personal File ( ) ER Visit
( ) Moving out of area ( ) Specialist consultation ( ) Legal ( ) Other : _____

Please release the following (check all that apply)

RECENT H&P		LAST 3 OFFICE VISITS	
LAB REPORTS		RADIOLOGY REPORTS	
HOSPITAL REPORTS		OTHER:	

· Please allow 15 days for processing.
· Incomplete information will delay processing.
· Use of this information for any other than the stated purpose is prohibited.
· This information is for the use of the designated recipient only and cannot be provided to any other agency.

CONSENT

I authorize the release of all information indicated, and I am aware that the records released may contain information relating to psychiatric or psychological testing, physical abuse, or drug and alcohol abuse. I authorize the release of HIV/HTLV/AIDS test results.

Signature of patient, parent, guardian, conservator, or patient representative. (Please circle)	Date
Witnessed by:	Date

Note: This consent is valid for 90 days. It may be revoked by the signer at any time.
This release is not valid retroactively.