AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name	Birth Date	Social Security Number
Address		Telephone Number ( )

I hereby authorize ______________________________
Facility Name

to release information for the medical records of ______________________________
Patient Name

To:
THE FAMILY PRACTICE CENTER
407 4th Street
Newport, TN 37821 P. 423 623-6240 F. 423 623-0102

For the following purpose: ______________________________

For treatment dates: See List Below
Specific dates must be indicated

Description of Information to be Used/Disclosed

1. One Year Office Visits
2. Recent Labs
3. Vaccination Records
4. PAP Smear
5. Mammogram
6. Colonoscopy

Expiration Date: ___/___/___ OR Expiration Event: ______________________________

(Note: Date or Event not to exceed 90 days from date of signature.)

_____ I acknowledge, and hereby consent to such, that the released information may contain psychiatric,
initials alcohol, drug abuse, HIV testing, HIV results, or AIDS information.

I understand that I may revoke this authorization at any time by notifying in writing the Medical Records Department of The Family Practice Center, P.C.. Such notice will not have any affect on any actions already made prior to this authorization. I understand that my healthcare, payment for my healthcare, enrollment or eligibility of benefits will not be affected if I do not sign this form. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by the privacy rules. This facility is released and discharged of any liability, and the undersigned will hold the facility harmless for complying with this Authorization for Release of Medical Information.

Date	Signature of Patient/Parent/Conservator/Guardian	Relationship to Patient

Fees/charges will comply with all laws and regulations applicable to release of information

FILE ORIGINAL ON MEDICAL RECORD