



Authorization to Release Medical Records

PATIENT INFORMATION:

Name (print)

DOB

SSN

INFORMATION TO BE RELEASED FROM:

Hitchcock Family Medicine, PLLC
5104 Hixson Pike
Hixson, TN 37343
(ph) 423-763-1942
(fax) 423-763-1842

INFORMATION TO BE SENT TO:

Name of facility or provider

Address

INFORMATION TO BE RELEASED: (check one)

☐ All medical records

☐ Specific information (please specify):

PURPOSE FOR WHICH THE DISCLOSURE IS BEING MADE:

PATIENT AUTHORIZATION:

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

MY RIGHTS:

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

Signature: _____ Date: _____
(Patient, guardian, or Authorized representative)

This authorization will expire one year from the date signed, unless otherwise noted or cancelled.