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**PATIENT INFORMATION:**

\_\_\_\_\_  
Name (print)

\_\_\_\_\_  
DOB

**INFORMATION TO BE RELEASED FROM:**

\_\_\_\_\_  
Name of facility or provider

\_\_\_\_\_  
Fax #:

\_\_\_\_\_  
Address

**INFORMATION TO BE SENT TO:**

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

**INFORMATION TO BE RELEASED: (check one)**

All medical records

Specific information (please specify): \_\_\_\_\_

**PURPOSE FOR WHICH THE DISCLOSURE IS BEING MADE:**

Continuing Medical Care

**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**

\_\_\_\_\_  
Signature (Patient, guardian, or Authorized representative)

\_\_\_\_\_  
Date

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