



AUTHORIZATION to RELEASE MEDICAL RECORDS

Family Health Center , 116 Concord Rd Suite 100, Farragut, TN 37934

Phone: 865.675.4342

Fax: 865.675.4343

Patient Name (Last, First, MI)

Patient Date of Birth

Patient Social Security #

I hereby authorized the following person(s) and/or organization(s) to release the indicated personal medical information to Family Health Center, PLLC OR for Family Health Center, PLLC to release my records to the following person(s) and/or organizations as indicated. To the extent that my medical record contains information regarding alcohol or drug treatment this is protected by Federal Regulation 42 CFR, Part 2, I authorized disclosure of such information. I understand that this information is not to be released to any person or facility except as provided by law or as I have indicated on this form. This release will continue until termination of treatment, or until _____ (enter date). I understand that I may revoke this release of information at any time. I understand, however that any release which was made prior to my revocation and which was made in reliance upon this authorization shall not constitute a breach of my rights to confidentiality. Unless I revoke this authorization prior to such time, this authorization to release information shall expire when the desired information is sent unless I have specified otherwise above.

Facility/Physician's Name(s): _____

Address / Phone #: _____

Specialty: _____

- Entire Chart / All Records
- Reports / Labs / Outside Studies
- Office Notes
- Summary of Treatment
- Other: _____

Release is: Permanent, TO Family Health Center Permanent, FROM Family Health Center
 Mutual, Records may be shared/discussed between offices until release is revoked

Signature & Printed Name of Patient (Legal Guardian if patient is under 18)

Date

Signature & Printed Name of Witness (Include Title if Applicable)

Date