Authorization for Release of Medical Records
Family Physicians of Greeneville
1410 Tusculum Blvd, Suite 2600, Greeneville, TN 37745
(Voice) 423-787-7000; (Fax) 423-787-7049

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/State	Zip	Phone

RELEASE FROM:			
Physician / Facility		Fax	
Address	City / State	Zip	Phone

RELEASE TO:			
Physician / Facility		Fax	
Address	City / State	Zip	Phone

RELEASE INFORMATION

Reason: [ ] Medical Care [ ] Transfer of care [ ] Personal file
[ ] Moving out of area [ ] Specialist consultation [ ] Legal

Please release the following (check all that apply)

[ ] ALL RECORDS	[ ] LAST _____ YEARS OF RECORDS
[ ] LABS / X-RAYS Dates:_____	[ ] OTHER: _____

CONSENT

I authorize the release of all information indicated (to be sent by fax or mail), including current and previous records from other facilities.
I authorize telephone communication by office staff of the above named facility.
I agree that a copy or fax of this release is a valid as the original.
I understand if the above named recipient is not a health plan or health care provider covered by HIPAA regulation, that the released information may be disclosed by the recipient and may no longer be protected by federal or state privacy laws.
I understand that the released medical records may contain information about:

- Psychological, psychiatric, or other mental impairments (excludes "psychotherapy notes" per 45 CFR 164.501)
- Drug abuse, alcoholism, or other substance abuse
- Sickle cell anemia
- Records which may indicate the presence of communicable or noncommunicable diseases, and tests for or records of HIV/AIDS
- Gene-related impairments (including genetic test results)

I understand I have a right to revoke this authorization by written notification to the Privacy Officer, except to the extent it has acted in reliance thereon before notice of revocation.
I understand that I can refuse to sign this authorization and the above-named office may not condition treatment on my signing of this authorization.

Signature of patient or legal guardian	Date
Witnessed by	Date

Note: This consent is valid for 12 months from the date signed, unless revoked prior to that date.