LAURELWOOD pediatrics
5050 Sanderlin Ave
Memphis, TN 38117
901-683-9371

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize_____and its physicians, employees, and agents to release or disclose to the below-named recipient my medical records as requested below:

Patient Name: _____ Date of Birth: _____

I hereby authorize the release of medical records to:

_____

_____

_____

_____

Please include name, address and phone number.

Purpose of disclosure: _____
For outgoing medical records, these fees apply: $ 20.00 pages 1-5 .50 > 6 pages + postage

This request and authorization applies to:

_____ All medical records

_____ Health care information relating to the following treatment, condition, or dates of treatment:

_____

_____

_____ Specific records to be released (eg. labs, imaging reports, other):

_____

_____

If you DO NOT WANT certain portions of your medical records released, please initial the box for the information you do not want released.

_____Substance abuse treatment/referral ____HIV/AIDS/STD

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 any disclosure of information carries with it the potential for an unauthorized re-disclosure which may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization. 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 Authorized Representative Date Signed

_____
Relationship to Patient

Revised 12/17/2016