Health Information Management Department
360 E.H. Crump Blvd. Memphis, TN 38126 (901) 261-2059 FAX (901) 432-0512

MR#

AUTHORIZATION FOR RELEASE OF PROTECTED INFORMATION

PATIENT'S NAME ADDRESS

CITY STATE ZIP Date of Birth Social Security Number

I hereby authorize:

- Memphis Health Center, Inc.
-

Name of Provider or Organization Address

City State Zip Fax Number

To release my confidential health information, as described below, to:

- Me
- Memphis Health Center
- Provider, Attorney or other Organization

Name Address

In the following manner: Mail Fax Pick-up Inspection Other

For the following purpose(s):

(If requested by the patient, a statement "at the request of patient" is sufficient.) My authorization is for the use and disclosure of the following records:

Statement of charges and payment
Mental health records
X-ray and other images
Other:

Records of MI-IC visits
Dental records
AIDS or HIV information
All of the above

My authorization pertains to information generated on the following date(s) or in the following time period:

My authorization is given freely with the understanding that:

- I may refuse to sign this authorization.
- I may revoke this authorization at any time, except where information has already been released in reliance on my Authorization, provided that my revocation in writing.
- Memphis Health Center may not condition my treatment on my provision of this authorization. .• This authorization is valid for one (I) year from the date it is signed or sooner is so specified by me, as indicated below.
- A photocopy or fax or this authorization is as valid as the original.
- Memphis Health Center, its directors, officers, employees, agents and volunteers are hereby released from any legal Responsibility or liability for disclosure or the above information to the extent indicated and authorized herein.

I further understand that any disclosure of records concerning diagnosis and/or treatment for alcohol or drug abuse is covered by Title 42 of the Code of Federal Regulations and if there is any such information; I hereby authorize the release of this information. This authorization also includes any information related to diagnosis and/or treatment of any psychiatric or mental illness or any state of infection with the HIV (AIDS) virus. I understand that any disclosure of information carries with it the potential for redisclosure by the recipient and that the information may not be subject to privacy rule protections; therefore MI-IC, Inc. is released from-any and all liability resulting from redisclosure.

THIS AUTHORIZATION WILL EXPIRE ON

Signature of Patient, Legal Guardian or Personal Representative Date

Signature of Witness Date

*Records are copied by IOD for a fee ofS21.85 for 1-40 pages and S .50 for each additional page. Fee must be paid prior to copying.

ID Provided YES NO (If requested)