AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

ONE PER REQUEST

Patient Full Name (print) _____DATE_____
SS# _____ DOB _____ is requesting the release of protected health information from the person/company/ agency/facility listed below to Optimum Internal Medicine and Pediatrics.

Name of Organization: _____
Address of Organization: _____
Phone number of Organization: _____

The information to be disclosed relates to service dates beginning on _____ and ending _____

☐ Entire Medical record	☐ Medication List	☐ Physical Therapy notes
☐ Demographic Information	☐ Immunizations	☐ Occupational Health Record
☐ History & Physical	☐ Test Results (lab, x-ray, etc.)	☐ Other: (specify)
☐ Medical/Surgical History	☐ Other Assessments	☐ Other: (specify)
☐ Physician Office visits	☐ Discharge Summary	☐ Other: (specify)

The purpose of this disclosure: ("Request of the Individual" is sufficient for patient-initiated releases)

☐ Request of Individual	☐ Change of Doctor	☐ Legal Investigation
☐ Referral to Specialist	☐ Insurance	☐ Other: (specify)
☐ Continuing Care	☐ Workers Comp	☐ Other: (specify)

Conditions and Notifications

This authorization for release of information expires 12 months from date of patient's signature. You may revoke this authorization at any time by writing to the Office Supervisor. However, such notification will not affect any actions taken in reliance on this authorization prior to the time of receipt of the revocation. You may inspect or request a copy of the health information to be used or disclosed, consistent with federal law. This authorization is being given to Optimum Internal Medicine and Pediatrics practice identified above and entity affiliated with Optimum Internal Medicine and Pediatrics.

Note: There maybe a processing fee charged to the patient to cover labor, copying, and supplies used to reproduce medical records.

Signatures

I herby authorize the use or disclosure of the personal health information as described above. I understand that I may refuse to sign this authorization, that this authorization is voluntary and that my health care and the payment for my health Care will not be affected if I do not sign this form. I also understand that the individual or organization authorized to receive the information is not a health plan or health provider, the released information may no longer be protected by federal privacy regulations and, therefore, may be subject to re-disclosure.

Signature of Patient/Personal Representative: _____
Print Name of Personal Representative: _____
Relationship of Representative to Patient: _____
Please Fax or mail my records to the following: Optimum Internal Medicine and Pediatrics
10044 Hwy 46 Bon Aqua TN 37025
Phone (931)996-4247 Fax (888) 814-0893
Email:
officemanager@optimumimpeds.com