Memphis Internal Medicine

A Division of
Consolidated Medical Practices of Memphis, PLLC
7205 Wolf River Blvd., Suite 100
Germantown, TN 38138
Telephone (901) 684-1322 Fax (901) 682-6368

James K. Ensor, M.D.
Mohan Gehi, M.D.
Tina M. Todd, APN, BC

Frederick Pelz, M.D.
Michael E. Posey, M.D.
David M. Sharfman, M.D.

Consent for Release of Medical Information

1. I hereby authorize ______________________________ to release information including, if any, psychiatric or psychological information, infections, or contagious disease information (including HIV/AIDS confidential information), and/or information about drug or alcohol abuse or treatment of same from the health record(s) of:

   Patient Name: ____________________________ DOB: ____________ SSN: ____________

   Patient Address: ____

   Covering the period(s) of treatment FROM: __________________ TO: ________________

2. Information to be released: COMPLETE RECORD: ______________ OTHER: ______________

3. Information is to be released to:

   Name: ____

   Address: ____

4. Purpose of disclosure: ____

5. I hereby release ________________________________ and its employees, agents, officers and affiliates from any and all liability, responsibility, claims, and damages which may result from the release of information authorized by this Consent for Release of Medical Information.

6. I understand that this Consent for Release of Medical Information is subject to revocation by the undersigned at any time, except to the extent that action has already been taken by ______________ ____________________ in reliance upon this consent. Unless otherwise stated below, this consent shall automatically expire ninety (90) days from the date set forth below, or upon the following date, event, or condition:

   ____

7. I have read and understand the Consent for Release of Medical Information, and have voluntarily and knowingly signed such consent.

   Date: ____________________ Signature of Patient: ________________________________

   If additional consent is necessary from a person authorized to give consent other than the patient:

   Signature of Patient's Representative: ______________________ Relationship: ______________