

MEMPHIS INTERNAL MEDICINE GROUP, P.C.

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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: _____