**JANICE S. ALGEA, MD PRIMARY CARE PEDIATRICS W. DAVID ALGEA, MD ELAINA HOGAN, PNP 8081 HIGHWAY 51 NORTH STEPHEN C. WILSON, PNP**

 **MILLINGTON, TN 38053**

 **(901) 873-4242**

  **(901) 873-4269 FAX**

**MEDICAL RECORD RELEASE FORM**

**PATIENT NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DOB:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **SS NUMBER:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RELEASE TO:**  **RELEASE FROM:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INFORMATION TO BE RELEASED:**

**\_\_\_\_\_\_\_ COMPLETE HEALTH RECORD \_\_\_\_\_\_\_ LAB/XRAY/DIAGNOSTIC REPORT**

**\_\_\_\_\_\_\_ PROGRESS NOTES ONLY \_\_\_\_\_\_\_ IMMUNIZATION RECORD**

**\_\_\_\_\_\_\_ OTHER**

This information is being disclosed for the following purpose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that I have the right to revoke this authorization at any time. I am aware that any revocation of this release must be in writing. I understand that the revocation does not apply to information that has already been released in response to this authorization. I understand that my health record may include information relating to sexually transmitted disease, sickle cell disease, AIDS, HIV and behavioral or mental health conditions,

I certify that this request has been made voluntarily and that the information above is accurate to the best of my knowledge. I am aware that I can refuse to sign this release and by doing so I will still be able to obtain treatment, payment and enroll in a health plan.

I am aware that this authorization will expire on \_\_\_\_\_\_\_\_\_\_\_\_ or automatically expire in 6 (six) months from the date it was signed. Please initial \_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Patient or Guardian Signature of Person authorized to sign for patient**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date Relationship to Patient**

Any information disclosed to you from our records is confidential and is protected by Federal law and all applicable state laws. Federal regulation 942C.F.R., Part 2 Prohibits you from making any further disclosure without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulation. A general authorization for the release of medical or other information is not sufficient for this purpose.