RIVERCITY FAMILY MEDICINE, PLLC

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____

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Release records to (name and address):

RiverCity Family Medicine, PLLC
6106 Shallowford Rd Suite 104
Chattanooga, TN 37421

Phone 423-802-1919 Fax 423-269-8747 or 423-269-6178

Release records from (name and address):

_____
_____
_____

Phone_____Fax_____

☐ **Medical Record from (insert date) _____ to (insert date) _____**

☐ **Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records received from other health care providers.**

☐ **Other: _____**

Include: (Indicate by Initialing)

_____ Drug, Alcohol or Substance Abuse Records **_____ Mental Health Records (Except Psychotherapy Notes)**

_____ HIV/HIDS - Related Information (Including HIV/AIDS Test Results)

_____ Genetic Information (Including Genetic Test Results)

Reason For Records Release:_____

I understand that I may revoke this authorization at any time and that unless an earlier date is specified it will automatically expire 12 months after the date affixed below. **Treatment, payment, enrollment or eligibility of benefits** are not conditioned on signing the authorization or a description of the consequences to the patient if he or she refuses to sign the authorization. Once the information is used or disclosed, it may no longer be protected. A copy of this authorization may be utilized with the same effectiveness as an original. My signature below indicates that I am authorized to obtain/release records on the patient(s) indicated and there is no court order denying guardianship, parental rights, or authorization to obtain/release these records.

Signature **Date** **Relationship to Patient**