TMS WELLNESS INSTITUTE
REQUEST FOR MEDICAL RECORDS

801 Noble St, Suite 400 Anniston AL 36201
Phone: 256-294-1727 Fax: 205-448-1187

PATIENT NAME: _____ DOB: _____

I, _____, hereby authorize _____ @

_____ _____
Complete Address Phone Number

to release to TMS Wellness Institute, Inc. the above named patient's Protected Health Information:

_____ all medical records

_____ the following records _____

I understand that the records described above may contain information relating to sexually transmitted disease, HIV/AIDS, notifiable diseases, alcohol and drug abuse treatment and/or mental health, and I specifically authorize the release of this information.

Patient or Personal Representative Signature: _____ Date: _____

Relationship to patient if signed by Personal Representative: _____

The Protected Health Information described above is to be released for the following purposes:

_____
(Life Insurance, Disability, at request of patient or parent, etc.)

*I understand that the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. *

I understand that TMS Wellness Institute, Inc. cannot condition treatment, payment, enrollment or eligibility of benefits on the signing of this authorization. I understand that I may revoke this authorization by sending written notice to TMS Wellness Institute, Inc. at the address checked off below. However, I understand that any revocation will not be effective as to any action taken in reliance of the authorization prior to receipt of the written revocation.

This authorization will expire on the following date or event: _____

Patient or Personal Representative Signature: _____ Date: _____

Relationship to patient if signed by Personal Representative: _____