



**MAURY REGIONAL
MEDICAL CENTER**

**AUTHORIZATION FOR RELEASE
OF MEDICAL INFORMATION**

Phone 931.380.4089 Fax 931.380.4092

PATIENT NAME: _____ MED REC#: _____
ADDRESS: _____
DATE OF BIRTH: _____ SS#: _____

I authorize **MAURY REGIONAL MEDICAL CENTER** to release copies or other facsimiles of information relating to my care to:

PURPOSE: Further Care: _____ Legal: _____ Insurance: _____ Other: _____

This information may include treatment or rehabilitation for drug and/or alcohol abuse, psychiatric treatment, or HIV test results, and AIDS diagnosis and/or an AIDS—related condition, if they did occur. I specify that this release is to include:

- | | |
|----------------------------|--|
| _____ Discharge Summary | _____ Operative Reports |
| _____ History & Physical | _____ Pathology Reports |
| _____ Consultation Reports | _____ Laboratory Reports |
| _____ EKG Reports | _____ Emergency Room Reports |
| _____ X-ray Reports | _____ Pharmacy Patients Prescription Profile |
| _____ Billing Records | _____ Other.....(Please specify) |

Treatment Dates: _____

The facility is authorized to furnish this information even though the confidentiality of the information may be protected by Federal and State law and regulations. The facility is hereby released and discharged of any liability, and I will hold the facility harmless for complying with this authorization. I understand that once the information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by Federal privacy regulations. I understand that I do not have to sign this authorization in order to receive treatment, payment or eligibility for benefits.

This authorization will remain in effect for 1 year. I understand that this authorization can be withdrawn at any time. Revoking this authorization stops further disclosures but cannot undo any disclosures that may have already occurred as requested in the original authorization.

Signature Date

If the above signature is not that of the patient, please explain why. Documentary evidence of guardianship may be required to accompany this form.

Medical Information released to : _____ Date _____

