# AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(All sections must be completed)


**VOGELFANGER & STRUBLE CLINIC, PLLC**

6005 Park Ave, Suite 630-B Memphis, TN 38119

Phone: (901) 767-1136 Fax: (901) 767-0476


## 1. PATIENT INFORMATION

Patient Name_____ Date of Birth_____

Social Security Number _____ Phone Number_____

## 2. INFORMATION TO BE RELEASED FROM (SELECT ONLY ONE)

☐ Vogelfanger & Struble Clinic, PLLC ☐ Other Facility/Provider:_____

Address_____

Phone Number_____ Fax Number_____

## 3. INFORMATION TO BE RELEASED TO (SELECT ONLY ONE)

☐ Vogelfanger & Struble Clinic, PLLC ☐ Other Facility/Provider_____

Address_____

Phone Number_____ Fax Number_____

## 4. PURPOSE OF RELEASE

Please give a brief description of why medical records are being released:

_____

_____

_____

## 5. INFORMATION TO BE RELEASED

☐ All Medical Records ☐ Medication and Diagnosis ☐ Laboratory/Pathology Records

☐ Progress Notes ☐ Other _____

***If you DO NOT WANT certain portions of your medical records released, please initial the line for the information you do not want released.**

_____Substance Abuse _____Psychological or Psychiatric treatment _____HIV/AIDS/STD

## 6. PATIENT RIGHTS

I hereby authorize the above-named recipient and its physicians, employees, and agents to release or disclose all of my medical records, including any specially protected records such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia, sexually transmitted disease, or HIV/AIDS infection.

I understand I have a right to revoke this authorization by written notification to the Privacy Officer, except to the extent it has acted in reliance thereon before notice of revocation. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure which may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization. I understand that I can refuse to sign this authorization and the above-named office may not condition treatment on my signing of this authorization.

## 7. SIGNATURE

_____ _____

**Signature of Patient or Authorized Representative** **Relationship to Patient**

_____ _____

**Print Name** **Date**

This authorization will expire on _____(Date may not exceed one year)