

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ do hereby authorize: _____

to release to: Memphis Internal Medicine and Pediatrics Assoc, PLLC.
Dr. Allison Stiles
1325 Eastmoreland #585 O: 901-276-0249
Memphis, TN 38104 F: 901- 276-0996

Medical information relating to my treatment in the said facility for the following purpose only: _____

And the following specific type data:

- Lab data
- Radiologic studies
- EKG and Cardiac studies
- Operative reports
- History & PE
- Discharge data
- Clinic visits
- Other _____

The expiration date or expiration event for this authorization is _____ or if no expiration date is known it will expire in 6 months after date below and it covers only treatment prior to that date. I understand I may revoke this authorization at any time with a written request to the Health Information Management department of the involved offices. The request must contain the signature of the patient or the patient’s legal representative and must be notarized. Revocation of this authorization is allowable only to the extent that the release of information has not already occurred and/or only if Memphis Internal Medicine and Pediatrics Assoc., PLLC has not taken action in reliance thereon. I understand that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization.

I further understand that any disclosure of records concerning diagnosis and/or treatment for alcohol or drug abuse is covered by Title 42 of the Code of Federal Regulations, and if there is any such information, I hereby authorize the release of this information. This authorization also includes any information related to diagnosis and/or treatment of any psychiatric or mental illness or any stat of infection with the HIV (AIDS) virus.

Memphis Internal Medicine and Pediatrics Associates, PLLC is hereby released from any legal liability that may arise from the release of the information requested. Please not that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected under applicable federal law.

Signature of Patient or Authorized Individual Date

Relation if Signed by Other than Patient Phone #

Address City State Zip Date of birth

Witness Date