AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: _____Date of Birth: _____

Patient Name: _____Date of Birth: _____

Patient Name: _____Date of Birth: _____

Release records to (name and address):

FirstChoice Family Care, PLLC

601 W Main Street

Byrdstown, TN 38549

Phone 931/864-3232 Fax 931/864-3230

Release records from (name and address):

_____

_____

_____

Phone_____Fax_____

IF YOU DO NOT WANT CERTAIN PORTIONS OF YOUR MEDICAL RECORDS RELEASED, PLEASE READ THIS SECTION CAREFULLY AND SPECIFY BELOW THE INFORMATION YOU DO NOT WANT RELEASED. OTHERWISE, YOUR COMPLETE RECORDS WILL BE RELEASED.

I authorize the health care provider to release the information specified to the organization, agency, or individual named on this request with the EXCEPTION of:

_____

_____

***REASON FOR RECORDS RELEASE (If moving provide forwarding address):** _____

_____

_____

_____

***It is our goal to improve our practice and better serve our patients. We appreciate your comments.**

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**