Reliance Medical Associates
107 Glen Oak Blvd, Suite 200
Hendersonville, TN 37075
Phone: 615-822-1993 Fax: 615-822-2055

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(All sections must be completed)

I hereby authorize the below-named 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.

PHI Recipient to Release Information:

Name: _____

Address: _____

Phone: _____

Fax: _____

Practice to Receive Information:

Reliance Medical Associates

107 Glen Oak Blvd, Suite 200

Hendersonville, TN 37075

Purpose or use of disclosure:

At the request of the individual/Physician: _____ Changing Physician: _____

This authorization applies to the following (select one of the following):

_____ All Medical Records

_____ Specific Date Range: _____ to _____

_____ Only the following records or types of health information (please include any dates):

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

_____ Substance abuse _____ Psychological or psychiatric treatment _____ HIV/AIDS/STD

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-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.

Print Name: _____ **DOB:** _____

Signature: _____ **Date:** _____

This authorization will expire on _____

(Date or Event may not exceed one year)