Authorization to Release Medical Record Information

Date: ______________________________

To: ______________________________ **Fax:** ______________________________ **Phone:** ______________________________

Requesting Physician:
David E. Smith, DPM, FAPWCA, FACFAOM
Matthew Truscello, DPM, FACFAOM
647 Dunlop Lane, Suite 209
Clarksville, TN 37040
Phone: (931)245-1920 Fax: (931)245-1929/1928
info@gfacenter.com

Check all that apply:		Dates Requested:
Office/Clinic Notes		
MRI/CAT/X-ray		
Laboratory Test Results		
Other		

Release:

1. All medical records at this facility.
2. Only some portion of records maintained at facility (dates of treatment, etc. specified above.)
3. Only records generated by this facility (not including records received from other sources.)

Initials
____
____
____

IF YOU DO NOT WANT CERTAIN PORTIONS OF YOUR MEDICAL RECORDS RELEASE, PLEASE READ THIS SECTION CAREFULLY AND THEN INITIAL THE INFORMATION YOU DO NOT WANT RELEASED. OTHERWISE, YOUR RECORDS WILL BE RELEASED AS SPECIFIED ABOVE.

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

Initials
______ Substance abuse, if any.
______ Psychological and/or psychiatric conditions, if any.

Initials
______ AIDS/HIC, if any.
______ Other (please specify.)

Expiration or revocation of authorization:

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 date affixed below.

Use of Copies:

A copy of this authorization may be utilized with the same effectiveness as an original.

Patient Name or Person Authorized to Sign for Patient:

Print Name: ______________________________ **Social Security #:** ______________________________

Signature: ______________________________ **Date of Birth:** ______________________________

Relationship to Patient: ______________________ **Witness:** ______________________________