TriState OB/Gyn

Patient Name: _____Birthdate: _____SS# _____

I hereby authorize: Name _____

Address _____

City, State, Zip _____

Phone _____ FAX _____

To release my medical records to:

TriState OBGYN
2900 Kirby Parkway Suite 11
Memphis. TN. 38119
Tel: (901) 345-4640
E-mail: contact@tristateobgynmd.com

Reason(s) to release PHI: _____

Type of access requested:

____ Copies of records
____ Past 3 years
____ Progress Notes
____ Lab Work
____ Radiology/Ultrasound
____ Consultation Report
____ ER Records
____ Operative Reports
____ Other _____

This authorization shall expire upon (check one)
____ Fulfillment of this request
____ Or, date _____

I acknowledge and hereby consent to such that the released information may contain alcohol, drug abuse, psychiatric, HIV results or AIDS information.

I understand that this authorization may be revoked by me at any time except to the extent that action has been taken in reliance upon it.

The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected.

I understand that the term “Complete Chart” for the release of PHI means that only records generated by this facility will be released. I have read the above and authorize the disclosure of the Protected Health Information.

_____ _____
Signature Date

Revised January 2011