MBODY HEALTHCARE

Authorization to Release Health Information

Name: _____

DOB: _____Phone: _____

Address: _____

I authorize Mbody Healthcare to: [ ] receive information from: [ ] send information to:

Name: _____

Phone: _____Fax: _____

Address: _____

For the purpose of: [ ] medical treatment [ ] insurance [ ] legal [ ] school [ ] other:

Information to be disclosed: dates of service from _____ to _____

For purpose of: [ ] medical treatment [ ] insurance [ ] legal [ ] school [ ] other: _____

	Clinic or Treatment Notes (most recent ____)		Admission H&P
	Laboratory Reports		Discharge Summary
	Radiology Reports		Consultation Reports
	Pharmacy Reports		Procedure Reports
	Immunization / Vaccination Reports		Other:

Specifics: _____

I understand that I have the right to revoke this Authorization at any time by sending written notice to each provider/facility listed above. Revocation will not affect any uses or disclosures made prior to receiving notice. Information used or disclosed in accordance with this Authorization may no longer be protected by federal law, and could be re-disclosed by the receiving third party and would no longer be protected. I may refuse to sign this Authorization and that Provider will not condition treatment, enrollment, or eligibility for benefits on whether I sign this Authorization. A reasonable copying/processing fee may be charged, as permitted by TCA § 63-2-102.

Expiration: [ ] One (1) year from signature date [ ] Upon completion of requested action.

Signature: _____Date: _____

OFFICE USE ONLY:
Information was released to authorized parties via: [ ] In person [ ] Mail [ ] Fax
Date: _____