Meharry Medical Group - Medical Records

Authorization for Release of Protected Health Information

Please complete all pages of this form and fax, email or mail and return to:
Meharry Medical Group - Attn: Medical Records Department
1005 Dr. D.B. Todd Jr. Boulevard, Nashville, TN 37208-3599
Fax: 877-894-3456
Email: medicalrecords@mmc.edu
Contact our office @ 615-327-5929 with questions.

Section I: Patient Identification

Patient Name:		Gender:	Date of Birth:
Address:			
City:	State:	Zip:	
Patient Phone#:	Email:		Fax#:

I request and authorize Meharry Medical Group to release medical information of the patient named above.

Section II: Request for Copy of PHI and Authorization for Disclosure of PHI

You have a right to inspect and obtain a copy of your health information for as long as we maintain the information in our records, with certain limited exceptions. Under certain limited circumstances, we may deny your request to inspect and/or copy your health information. If access is denied, you may request that the denial be reviewed. Instructions for the review process will be included with any denial. You also agree to pay any fees (if applicable) associated with copying, and mailing the above records. Please note that we accept cash or check (for the exact amount); we do not accept credit cards.

RELEASE RECORDS TO:
Indicate Preference:
☐ **Mail** – *Please mail the copies I requested to address below (if same as patient, please note).*
☐ **Email** – *Please email the copies I requested to email address below.*
☐ **Fax** (For Doctors or Healthcare Providers Only) – Please fax copies to the number below.
I hereby authorize Meharry Medical Group to release my protected health information to:

Person/Practice/Organization:				
Address:		City:	Sate:	Zip:
Email:				
Fax:				

Section III: Purpose of Use and Disclosure of Personal Health Information ("PHI")

☐ Medical Treatment ☐ Personal Use ☐ Insurance/Billing ☐ Attorney/Legal Case

☐ Disability Claim ☐ Other (Specify):_____

Section IV: Health Information to be Accessed or Disclosed (*to be completed by all requestors*).

Information to be Disclosed. The information to be disclosed includes only those items checked below, with respect to services provided below.

From (Date): _____ to (Date): _____

Or *Specific Date*: _____

☐ **All Medical Records**

Or Specific Categories

☐ Discharge Summaries ☐ Progress Notes ☐ Pathology Reports ☐ Radiology Reports

☐ Consultation Reports ☐ Lab Reports ☐ History/Medical Summary ☐ Immunization Records

☐ Diagnostic Records ☐ Billing Records

Other (Specify): _____

I understand that my medical record may include information on diagnosis or treatment related to psychiatric or psychologies conditions, drug or alcohol abuse, and acquired immune deficiency syndrome (AIDS) or HIV status. I agree that any information about such diagnosis or treatment may be released.
I also understand that if I do not ask for my legal medical record or specify the records I want, the Medical Records Department will send an abstract of my legal medical record.

PLEASE CHECK THE STATEMENT BELOW THAT APPLIES

(You must check one): I Do_____ Do Not_____ authorize this information to be released.

I would like to limit the information to: _____

I understand that:

- I may revoke this authorization at any time by sending a written notice to the clinic. However, the revocation will not have any effect on any uses or disclosures the clinic may have made before the revocation was received.
- Unless I revoke the authorization earlier, this authorization will automatically expire six (6) calendar months after the date this authorization is signed.
- Information used or disclosed in accordance with this authorization may no longer be protected by federal law, and could be redisclosed by the receiving party.
- I may refuse to sign this Authorization and that the clinic will not condition treatment on whether I sign this Authorization.
- I get a copy of this form after I sign it.

I certify that:

☐ I am the patient, and the identification that I have provided is true and correct.

☐ I am the patient's authorized representative, and that the identification and proof of authority that I have provided are true and correct.

Printed Name of Patient: _____

Signature of Patient: _____ Date: _____

Printed Name of Legal Representative: _____

Signature of Legal Representative: _____ Date: _____

Relationship to Patient: _____