Patient's Full Name_____ DOB_____

I authorize the release of my medical records:

TO: **Portland Medical**
Address: 307 S Broadway
City, State, Zip Portland Tennessee 37148
Phone Number 615-323-9158 Fax: 615-323-9100
FROM:_____
Address:_____
City, State, Zip_____
Phone Number_____

For the purpose of:
____Permanent transfer to new provider
____Continuity of medical care
____Insurance of other third party reimbursement
____Other (Specify)_____

This release includes specifically (circle all that apply)

Office Notes	Laboratory Reports	Complete Medical Records
Radiology/Reports	History and Physical	EKG
Other_____		

1. I acknowledge and herby consent to such that the release of information may contain information regarding alcohol, drug abuse, psychiatric, HIV testing, AIDS, or other sensitive information ____(initials of pt).
2. I may refuse to sign the authorization and my treatment will not be conditioned upon signature of this authorization (except for non-health related services such as pre-employment testing, life insurance exam, or drug screenings).
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect or actions taken prior to receiving the revocation. Further details may be re-disclosed.
4. If the requestor or receiver is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations and ;may be re-disclosed.
5. I understand that I may see and obtain a copy of the information described on this form for a reasonable copy fee, if I ask for it.
6. I will receive a copy of this form after I sign it or a copy will be. Maintained in my permanent record.

I have read the above and authorize the disclosure of the protected health information as stated.

_____ _____
Signature of Patient /Guardian/Patient Rep **Date:**