Church Health
1350 Concourse Avenue, Suite 142
Memphis, TN 38104
901 272.0003
(FAX) 901 261-8830
Authorization for Release of Church Health Medical Information

Patient Name (print)	Date of Birth	SS #	MR #
Address		Telephone #	

I hereby authorize Church Health

To release information from the medical records of

_____

Patient Name

Send/give Records To:
Name_____Address_____

City_____State_____Zipcode_____

Name/Address of person/organization to which disclosure is to be made

Fax # _____Phone # _____

I want the following records sent: Physician and/or provider notes for the past 12 months, vital sign flow sheet, lab test results, medications prescribed, x-ray and mammography reports will be included. ***Records about HIV status and sexually transmitted diseases to be included unless otherwise specified.***

Note: Counseling or psychotherapy notes require specific, separate request and review by staff before release.

Please specify if other than described

_____.

This authorization is valid for one year from date of signature or until _____ unless it is revoked by written request. It covers only treatment(s) for the dates specified above.

I, the undersigned, have read the above and authorize the staff of Church Health to disclose such information as herein contained. I have the right to revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon it. I understand that I do not need to sign this form to get treatment, payment, health plan enrollment nor eligibility. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclose by the recipient and may no longer be protected. My health records may be provided via Ciox Health, a third party service. I hereby release and hold harmless Church Health from all liability and damages resulting from the lawful release of my Protected Health Information. I understand I may have a copy of this form if I want it.

_____	_____	_____
Date	**Signature of Patient/ Parent/Conservator/Guardian**	**Authority/Relationship to patient**

Records picked up from clinic by anyone other than the patient require individual to have photo identification.