Masters Family Medical, PLLC

234 West Central Ave
Jamestown, TN 38556
(931) 879-8139

117 West Commercial Ave
Monterey,TN 38574
(931) 310-2900

Authorization to Release Information

Please Print Clearly

Name: ____

Last First Middle

Address: ____

(Street) (City) (State) (Zipcode)

Phone: ______________________ Date of Birth:______________

Name of Healthcare provider/Doctor/Hospital etc:______________________________

Address:____

City.State/Zipcode:____

For the purpose of review/examination, I further authorize you to release any and all information, including HIV/AIDS status related information, substance abuse and psychiatric/mental health information that my be contained in my medical records, including copies of all or any portion; hereby waiving there as to any privilege of communication conferred on myself, my personal representative or heirs of any amendments thereto.

Information requested:

- ☐ Office visit notes dates:______________________
- ☐ Lab results
- ☐ Imaging
- ☐ Entire chart

Reason for request:____

This authorization will expire one year from the date signed. I understand that I may revoke this consent at any time except that action has been taken and reliance thereon.

Signed ______________________ ______________________

Relationship to patient if signed by other than patient

Witness ______________________ ______________

Date