OccuMed

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MEDICAL INFORMATION RELEASE REQUEST

I hereby authorize the use or disclosure of personal health information as described below:

- ☐ Entire medical record
- ☐ Initial Evaluation
- ☐ Test Results
- ☐ Progress Notes
- ☐ Billing Statement
- ☐ Other components (specify) ____________________
- ☐ Mental Health/Psychotherapy Notes

1. **Release my protected health information**, which is described above to the following person(s) or group of persons:

☐ Myself	☐ Physician	☐ Other
Mail to me at:	____________________	____________________
____________________	1785 Nonconnah Blvd	____________________
____________________	#120	____________________
____________________	Memphis, TN 38132	____________________
☐ **Will pick up records**	Phone 901-345-6700	____________________

2. **Request my protected health information from :**

____

Phone number____________________ **Fax number**____________________

3. I understand that if the person or entity that receives the above information is a not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

4. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by Robinson and Associates in reliance on this authorization, by sending a written revocation to Robinson and Associates, 1785 Nonconnah Blvd. #120, Memphis, TN 38132.

5. I understand that I am not required to sign this authorization form and that OccuMed will not withhold the provision of treatment or payment to me as a condition of the signing of this authorization. I understand that OccuMed may condition the provision of healthcare to me that is solely for the purpose of created protected health information for disclosure to a third party on the signing of this authorization.

Patient Name: ____________________ ____________________ __________
Last First M.

_____/_____/_____ _____-_____-_____
Patient Date of Birth Patient Social Security Number

Authorized Representative ____________________ ____________________ __________
(if Applicable) Last First M.

Representative's Relationship to Patient: Parent Spouse Other ____________________
(Circle One)

Patient / Authorized Representative Signature ______________________________

Date _____/_____/_____ OccuMed Witness ______________________________