DeSoto Family Medical Center
Quality Care for Your Entire Family

Chart _____

Authorization to Release Medical Records/Information

I hereby authorize: _____
(Name of Physician, Hospital or Healthcare Provider)

_____
(Street Address, City, State, Zip Code) (Phone/Fax)

To Furnish to: _____
(Name of Requestor)

_____
(Street Address, City, State, Zip Code) (Phone/Fax)

The following information contained in the patient records of:

Patient Name: _____ Address: _____

DOB: _____

All fields must be completed in order for authorization to be valid

___ Yes ___No The entire medical record, ***excluding*** mental health information, alcoholism and drug abuse information, and HIV/acquired immune deficiency syndrome (AIDS) records.

To be disclosed, the following items must specifically be checked:

___ Mental Health Records ___ Alcoholism Records

___ Drug Abuse Records ___ HIV/Acquired Immune Deficiency Syndrome (AIDS) Records

___ Other/Specific Information: _____

I understand that I may revoke this authorization at any time and that unless an earlier date is specified it will automatically expire 12 months after the date affixed below.

Guardian authorized to sign for patient (print):

_____ _____
Patients Name (Print) Print Name

_____ _____
Patients Signature Signature

Date: _____ Relationship:_____Date:_____

75 Physicians Lane Southaven, MS 38671 662-393-7722 Fax 662-393-7756