



7945 Wolf River Blvd
 Germantown, TN 38138
 APPOINTMENTS: 901-516-6777
 Facility Phone: 901-752-5100

Authorization for Release to Methodist Breast Center - Germantown

I, _____, do hereby authorize _____
Patient's Name Agency or Individual
 to release to **METHODIST BREAST CENTER**

Medical information relating to my treatment in said facility for the following purpose only:

Comparison studies - All mammo studies and reports
 The information released shall be limited to the following time period(s) or illness:

Include also the following specific type data (**check all that apply**):

- | | | |
|---|---|--|
| <input type="checkbox"/> Discharge data | <input checked="" type="checkbox"/> X-ray | <input type="checkbox"/> EKG |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Clinic visits | <input type="checkbox"/> Lab |
| <input type="checkbox"/> Operative Report | <input type="checkbox"/> E.D. Records | <input type="checkbox"/> All information in medical record |
| <input type="checkbox"/> Other _____ | | |

Expiration Date:

- The expiration date or expiration event for this authorization is _____
- If no expiration date or period is known it will expire **six (6) months** after the date recorded below.
- This authorization covers only treatment prior to the date recorded below.
- I understand I may revoke this authorization at any time with a written request to the Health Information Management Department of the above-named facility.
- The request to revoke authorization must contain the signature of the patient or the patient's legal representative and must be notarized.
- Revocation of this authorization is allowable only to the extent that the release of information has not already occurred and/or only if facility has not taken action in reliance thereon.
- I understand that treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining this authorization..
- I further understand that any disclosure of records concerning diagnosis and/or treatment for alcohol or drug abuse is covered by Title 42 of the Code of Federal Regulations, and if there is any such information, I hereby authorize the release of this information.
- This authorization also includes any information related to diagnosis and/or treatment of any psychiatric or mental illness or any state of infection with the HIV (AIDS) virus.

Methodist Le Bonheur Healthcare and above noted facility is hereby released from all legal liability that may arise from the release of the information requested. Please note that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected under applicable federal law.

 Signature of Patient or Authorized Individual

 Date

 Relation if signed by Other than Patient

 Patient Social Security Number

 Street Address

 Phone Number

 City State Zip Code

 Date of Birth

Photo ID Provided ____yes____no. If no, the form of patient ID must be stated _____

Witness Date _____