661 E Lane Street, Shelbyville, TN 37160 Phone: 877.684.9987 Fax: 877.455.5550

MEDICAL INFORMATION (HIPAA) RELEASE FORM

RESIDENT NAME: _____

DATE OF BIRTH: _____

RELEASE OF INFORMATION

I AUTHORIZE THE RELEASE OF INFORMATION INCLUDING PRESCRIPTION RECORDS RENDERED TO ME AND CLAIMS INFORMATION. THIS INFORMATION MAY BE RELEASED TO:

_____ RELATIONSHIP: _____

_____ RELATIONSHIP: _____

_____ RELATIONSHIP: _____

_____ RELATIONSHIP: _____

THE RELEASE OF INFORMATION WILL REMAIN IN EFFECT UNTIL TERMINATED BY ME IN WRITING.

MESSAGES

IS IT OKAY TO LEAVE MESSAGES IF UNABLE TO REACH YOU? YES _____ NO _____

IF UNABLE TO REACH ME:

☐ LEAVE A DETAILED MESSAGE ☐ LEAVE A MESSAGE ASKING ME TO RETURN YOUR CALL

SIGNATURE

☐ RESIDENT SIGNATURE: _____ DATE: _____

OR

☐ I _____ AM POWER OF ATTORNEY FOR RESIDENT.

A COPY OF THE POA PAPERWORK MUST BE ATTACHED TO VALIDATE

POA SIGNATURE: _____ DATE: _____