CUMBERLAND FAMILY PRACTICE

264 NEW SHACKLE ISLAND RD STE #107 HENDERSONVILLE, TN 37075
PHONE: 615-824-4244
FAX: 615-824-5916
Dr. Raul Couret | Dr. Steven Faulks | Dr. Guru Medam | Dr. David Montgomery

PATIENT NAME: _____

ADDRESS: _____

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

CUMBERLAND FAMILY PRACTICE IS AUTHORIZED TO **FURNISH TO** OR **RECEIVE FROM**:

FACILITY/DOCTOR NAME: _____

ADDRESS: _____

PHONE: _____ FAX: _____

I AUTHORIZE RELEASE OF THE FOLLOWING MEDICAL RECORDS

_____ I GIVE PERMISSION TO RELEASE **ALL** MY MEDICAL RECORDS including information and records or copies of **INTIAL** records relating the history, diagnosis, treatment, or services rendered to me in connection with any condition or disease. This includes permission to release potentially sensitive information which may include information concerning my treatment of mental illness, Human Immunodeficiency Virus (HIV), alcoholism, drug use or dependency, venereal disease, sexual assaults, illegitimacy of birth, communication to social workers and/or psychologists, if any.

____ I GIVE PERMISSION TO RELEASE MY MEDICAL RECORDS, SPECIFICALLY DESCRIBED BELOW
INTIAL

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I release Cumberland Family Practice and the providers therein, the recipient/discloser listed above, and any of their provider and staff from all responsibility or liability that may arise with this authorization. This authorization is valid for **12 months** from the date of signature. I understand that I may cancel this request with written notice but that it will not affect any information released prior to the cancellation notice. I understand that information used or disclosed may be subject to re-disclosure by the recipient of this request and will no longer be protected by federal regulations.

_____ _____

PATIENT OR LEGALLY AUTHORIZED INDIVIDUAL'S SIGNATURE **DATE**

NO DISCS! LAST TWO YEARS OF RECORDS ONLY.