CUMBERLAND FAMILY PRACTICE

264 NEW SHACKLE ISLAND ROAD

SUITE 107

HENDERSONVILLE, TN 37075

615-824-4244 PHONE

615-824-5916 FAX

Dr. Raul Couret, Jr., Dr. Steven Faulks, Dr. David Montgomery, Dr. Guru Medam

Patient Name: _____

Address: _____

Date of Birth: _____ SS #: _____

Cumberland Family Practice is authorized to **FURNISH TO or RECEIVE FROM** (Circle Choice):

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 records relating to 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/dependency, venereal disease, sexual assaults, abortion, illegitimacy of birth, communication to social workers and/or psychotherapies, psychologist, if any.

_____ I GIVE PERMISSION TO RELEASE ALL MY MEDICAL RECORDS specifically described below:

_____

_____

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

_____ _____

Patient Signature (Parent's Representative if Minor) Date