Consent and Authorization for Release of Medical Information

Pursuant to Federal Guidelines concerning my right to confidentiality, I, **d.o.b** authorize to release my medical record information concerning my medical record to:

Neurology Outreach Clinics, LLC; 6005 Park Ave, Ste 722B; Memphis TN 38119; P: 901-683-8448, F: 844-203-0802

I specifically consent only to the release of information of medical record pertaining to:

☑ All Records ☐ History/Physical ☐ Progress Notes ☐ Hospitalization ☐ Radiology Reports
☐ Other

I understand that I may revoke this consent to release information at any time; however, I also understand that any release which has been made prior to my revocation and which was made in reliance upon this authorization shall not constitute a breach of my right to confidentiality unless I revoke this authorization prior to such time, this authorization to release information shall expire in one year. At this time, no express revocation shall be needed to terminate my consent.

Sign

Date:

(Signature of Patient)

Sign

Date:

(Witness)

If the patient is either <u>under age</u> or has a <u>guardian</u> appointed by the court, this release must be signed by the patient's parent or guardian.

Sign

Date:

(Parent or Guardian) (Relationship to Patient)

I also give my consent to any information concerning ☐ STD/HIV/AIDS and/or Family Planning and ☐ Alcohol or Drug Abuse Records.

Sign

Date:

(Signature of Patient)

Sign

Date:

(Witness)