David J. Weber, P.C.
Housecall Family Medicine
407 Stonewall Street, Memphis, TN 38112 • Phone (901)278-6963 • Fax (901) 274-5224

AUTHORIZATION FOR RELASE OF INFORMATION

I, _____ do hereby authorize _____ to release protected
Patient Name **Name of previous physician or facility**

healthcare information to:

David J. Weber, M.D.
407 Stonewall Street
Memphis, N 38112
Phone (901) 278-6963
Fax (901) 274-5224 (please fax all requested information to this number)

The information released shall be limited to the following time period: _____, and the following specific part or parts of the health care information.

History & Physical	Discharge Summary	X-Ray
Operative Report	Clinic Visit	Lab
ED Record	Psychosocial Assessment	Demographic Information
Insurance Information	All information in chart	Other _____

I understand that this authorization is voluntary. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain services, however withholding of healthcare information may affect my healthcare. I also understand that if the person or organization I authorize to receive the information described above is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. The expiration period for this authorization is _____; if I have not designated a time period it will expire six (6) months after the date of my signature below and it covers only treatment prior to the at date. I may revoke this authorization at any time by notifying the office manager of Housecall Family Medicine, in writing. Revocation will only be effective if the release of information has not already occurred or is already in progress. I understand that I may see and copy the information described on this form if I ask for it, and I can obtain a copy of this form after I sign it if I desire.

I also understand that Title 42 of the Cod of Federal Regulations covers any disclosure of healthcare information concerning diagnosis and treatment of alcohol or drug abuse. If such information is contained in my records, I hereby authorize the release of such information. I also authorize the release of any information in my health care record related to diagnoses and/or treatment of psychiatric or mental illness, any stage of infection with HIV (AIDS) virus, or sexually transmitted disease.

I understand that by signing this authorization I am releasing Housecall Family Medicine from all legal liability that may arise from the release of the information requested.

_____ _____
Signature of patient or authorized individual Date

_____ Caregiver
Relationship if signed by other than patient Conservator
Healthcare Power of Attorney
_____ Guardian
Address of Patient Caregiver

_____ _____
City State Zip Phone Number

_____ _____
Witness Date Date of Birth