Betty Jo Dulaney, M.D. P.C.
2157 Judicial Drive
Germantown, TN 38138
PH# (901)309-6745 Fax# (901)309-6758

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(Important: All sections MUST be completed.)

Patient: _____Birth Date:_____

Address:_____ Phone: ( )_____

_____SS#:_____

RELEASE FROM: _____Release To: Betty Jo Dulaney, M.D.

_____ 2157 Judical Drive_____

Secure

_____ Germantown, TN 38138 Fax#(901)309-6758

Specific type of information to be released: [ ] any/all records [ ] Diagnostic reports [ ] Lab results
[ ] Chart noted [ ] Consultation noted [ ] Operative notes
[ ] Other for date range: _____ to_____
(if no time period specified, record from previous 5 years only will be released)

Purpose of disclosure: [ ] Transfer of Care – Reason:_____
[ ] Disability [ ] Worker's Comp [ ] Social Security [ ] Insurance
[ ] Attorney Request [ ] Other:_____

I understand that my medical records may contain information **related to communicable diseases and infection information** as defined by statute and **Tennessee Department of Public Health Rules** (which include venereal disease "VD", tuberculosis "TB", Hepatitis (any form), Human Immunodeficiency Virus "HIV", Acquired Immunodeficiency Syndrome "AIDS" and AIDS Related Complex "ARC"; **Alcohol and/or drug abuse treatment information** protected under regulations in 42 Code of Federal Regulations, Part 2; and **Mental Health treatment records, Psychological services** and/or **Social Services** information including communications made to or by a social worker, psychologist or psychiatrist.

I understand I have to right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the Privacy Officer. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire after one (1) year.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-discloser and the information may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization. If I have questions about disclosure of my health information, I can contact the Privacy Office at the disclosure location.

_____ _____
Signature of Patient or Legal Representative Date

_____
If signed by Legal Representative, relationship to Patient