Tennessee Valley Internal Medicine, P.C.

Authorization for Release/Request of Medical Records

Name of Patient (Last, First MI): ____

Patient DOB: _______________ Patient SSN: ________________________________

Purpose of Release: ____

Name and Address of Party Information is Being Released To:

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Name and Address of Party Information is Being Released From:

____

____

I hereby authorize the release of any and all medical information (progress notes, lab results, X-ray and diagnostic results and any mental or substance abuse records) including diagnosis, treatment and prognosis of the injuries and/or illnesses received by the above name person on or subsequent to the date of the injuries and/or illnesses. Authorization expires in 365 days unless revoked in writing.

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Signature of Patient or Legal Guardian

____

Date

3809 Sullivan Street, Suite 7
Madison, AL 35758
(256) 428-1096
(256) 428-1097 fax