**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS**

TO REQUEST RELEASE OF MEDICAL INFORMATION PLEASE COMPLETE AND SIGN THIS FORM

I, hereby voluntarily authorize the disclosure of information from my health record. (Name of Patient)

Patient Information:

Patient Name: Record Number: \_

Address: Date of Birth:

Information Requested:

Purpose of Release:

The Information Is To Be Provided To:

Name of Person/Organization/Facility: Medical Direct Care, PLC

Address: 190 Hatcher Ln, Suite B, Clarksville, TN 37043

Phone Number: 931-221-0902

Patient’s Signature or Patient’s Representative Date

Printed Name of Patient’s Representative Relationship of Patient

**This information is to be released for the purpose stated above and may not be used by recipient for any other purpose.**

PLEASE MAKE A COPY OF THIS RELEASE FOR YOUR RECORDS

HIPAA Authorization For Release of Medical Records