Trace Medical Clinic
530 Veterans Memorial Drive
Kosciusko, MS 39090
662-289-9155 fax: 662-289-7752

AUTHORIZATION AND REQUEST TO RELEASE INFORMATION TO TRACE MEDICAL CLINIC

PATIENT NAME____

ADDRESS____

BIRTHDAY______________SOCIAL SECURITY #__________________

I HEREBY AUTHORIZE ____
(Name of facility, doctor or other provider)

MAILING ADDRESS____

TO RELEASE TO Trace Medical Clinic

INFORMATION TO BE RELEASED______________________________
(Limitations on date(s) or procedures)

If no limitations stated, I further authorize and request that you provide copies thereof with no limitations placed on dates, history of illness, and/or diagnostic information.

The information to be released is confined to the following:

__Complete Records __Physician Orders
__Physician Progress Notes __ Emergency Room Records
__Laboratory Data
__X-Ray reports
__EKG
__Treatment Plans

The consent will expire 90 days from the date signed. I understand that I may revoke this authorization at any time, in writing to the Medical Record Department. The information authorized for release may include information which may be considered a communicable or Venereal Disease which may include but are not limited to disease such as Hepatitis, Syphilis, Gonorrhea and HIV/AIDS.

____
Signature of Patient or Legal Guardian Relationship to Patient Date

____
Witness Date