MEMPHIS MUSLIM MEDICAL CLINIC
a project of
Memphis Muslim Medical Services, Inc.
1055 Stratford Road, Memphis, TN 38122 • Phone: (901) 685-3901 • Fax: (901) 685-3903
www.muslimclinic.org

AUTHORIZATION FOR RELEASE OF INFORMATION

CONSENT AND AUTHORIZATION TO RELEASE INFORMATION OR MEDICAL RECORDS UNDER THE PROTECTION OF STATE AND FEDERAL LAW (INCLUDING BUT NOT LIMITED TO: DRUG, ALCOHOL, PSYCHIATRIC, SEXUALLY TRANSMITTED DISEASES, OR HIV RELATED TREATMENT).

I, _____ the undersigned, hereby authorize

Memphis Muslim Medical Clinic, 1055 Stratford Road, Memphis, TN 38122
Phone: (901) 685-3901 Fax: (901) 685-3903

TO RELEASE the following information from my medical records pertaining to:

_____

(Indicate specific dates, types of information, extent of information or all information)

Purpose of disclosure: _____

The above information may be released to:

_____

(Name of specific Person/Organization/Institution) (Phone/Fax)

_____

(Complete Address)

I understand that I may revoke this authorization at any time by submitting a request in writing to the Memphis Muslim Medical Clinic, as stated in our Notice of Privacy Practices; however, I also understand that any information which has been disclosed prior to my revocation and which was made in reliance upon this authorization shall not constitute a breach of my right to confidentiality. Unless I revoke this authorization prior to such time, or occurrence of such event or condition, this authorization to release information shall expire:

_____

(State: date, event, or condition of expiration)

If I fail to specify expiration date, event or condition, this authorization will automatically expire in six (6) months.

I understand that MMMC will not withhold care or treatment if I do not sign this authorization unless:

1. The treatment is related to research and this authorization allows MMMC to release information to the researcher, or
2. The only purpose of the treatment is to provide information to a third party, and this authorization allows MMMC to release the information to the third party.

I understand that it is possible that the information release pursuant to this authorization may be redisclosed by the recipient because it is no longer protected by MMMC or by privacy laws.

I hereby state that I have read and fully understand the above statements as they apply to me.

Signature of Patient: _____ Date: _____

(If patient is either under legal age or has a guardian appointed by the court, this release must be signed by the patient's parent or guardian)

Signature of Parent/Guardian): _____ Date: _____

Relationship to Patient: _____

Signature of Witness: _____ Date: _____