McMinn Clinic
3125 Independence Drive
Suite 108
Homewood, AL 35209

Phone: 205-868-1313
Fax: 205-868-1314

MEDICAL RELEASE

I understand that information released may obtain sensitive information concerning psychological, drug alcohol, and/or HIV (AIDS) test findings.

I,_____(PRINT FULL NAME), request McMinn Clinic to OBTAIN / RELEASE (circle one) medical information on:

PATIENT INFORMATION:

Patient's Name:_____D.O.B._____

Social Security Number:_____-_____-_____

Specific Dates of Treatment:_____

McMinn Clinic is authorized to SEND / RECEIVE (circle one) medical information to / from:

Name of individual, hospital, or firm:_____

Street Address:_____

City/State/Zip Code:_____

State the reason or purpose for disclosure of this medical information:_____

_____

The following information is needed (disclosure will be limited to ONLY the items checked below):

____Discharge Summary	____History and Physical Exam	____Medication Sheet
____Operative Report	____Final Diagnosis and Procedure	____Other (Specify):
____Pathology Report	____X-Ray and Imaging	_____
____Lab	____Anesthesia Sheet	_____

This authorization may be revoked in writing at any time by the patient or his/her legal representative. Such revocation shall not apply retroactively to any previous disclosures made based on the original authorization. Unless revoked, this authorization shall be effective for a period not to exceed 90 days from the date of the authorizing signature.

I release McMinn Clinic and its staff from any and all liability that may result from this action.

_____ _____

Signature of patient or legal representative Date