North Main Medical

3094 North Main Street Crossville, TN 38555

(931) 644-5423

Medical Information Release Form

(HIPAA Release Form)

Name: _____ Date of Birth: _____/_____/_____

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

_____

[ ] Information is not to be released to anyone.

Please call [ ] my home [ ] my work [ ] my cell Number: _____

The best time to reach me is (day) _____ between (time) _____

Signed: _____ Date: _____/_____/_____

*This Release of Information will remain in effect until terminated by me in writing.

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have read and understand North Main Medical's Privacy Practices.
I acknowledgethat I may request and will be provided a copy at any time from the office.
I also understand that I am able to take the copy with me that I read prior to signing this notice.

Signature: _____

Witness: _____ Date:_____/_____/_____