

Client Number: _____



Release of Health Information
LMU-DeBusk College of Osteopathic Medicine,
Department of Outpatient Services – University Medical Clinic

I, _____, hereby authorize the use, release and disclosure of my health information as described in the authorization below:

Release From/To:

Release To/From:

LMU - DeBusk College of Osteopathic Medicine
Department of Outpatient Services- University Medical Clinic
PO Box 4408, 165 Westmoreland Street
Harrogate, Tennessee 37752
423-869-7193 423-869-7195 (Dedicated Fax)

Description of Information Requested:

Right to Revoke: I understand that I have the right to revoke this authorization at any time by notifying the Medical Provider in writing. I also understand that the revocation is only effective after it is received and logged by the Medical Provider. I understand that any use of disclosure made prior to the revocation under this authorization will not be affected by a revocation.

I understand that after this information is disclosed, federal law might not protect it and the recipient might re-disclose it.

I understand that I am entitled to receive a copy of this authorization and that it will expire twelve (12) months from the date below.

The information requested by the provider identified in this document is expressly authorized by the undersigned to release the requested information under the authority of a photocopy of my signature on this release.

Signature of Patient or Guardian: _____ **Date:** _____
Patient Date of Birth: _____ **Client Social Security Number:** ____ - ____ - _____

If a personal Representative executes this form, which Representative warrants that he or she has the authority to sign this for on the basis of: _____