

Patient MRN

NAME

DOB

Patient stamp above - for HIS use only



UT Medical Group, Inc.

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901-347-8331 • Fax: 901-347-8188

Family and Friends Release Agreement

Please PRINT or TYPE and return completed form to the above address.

Dear Patient:

Please use this form to provide us with written permission to disclose confidential information (such as lab results, test results, prescription information) to a specific individual (such as a spouse, family member, or close personal friend).

Patient Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Date of Birth: ___ / ___ / _____ Social Security Number: _____ - _____ - _____ Phone Number: _____

1. I authorize UTMG to disclose confidential information relating to my care as specified in Section 2 below:

2. I authorize disclosure of my information to (check all that apply):

- Spouse Family member (specify relationship) Other (specify relationship)

Name: _____

Relationship: _____

Address _____

City: _____ State: _____ ZIP: _____

Telephone: _____

3. I understand that I can revoke this authorization at any time by sending my written request to: UTMG Health Information Services Department at 920 Madison Avenue, Suite 415, Memphis, TN 38103; (901) 448-4530. Such written revocation will be effective only after receipt and processing by UTMG. I understand that the revocation will not apply to information that has already been used or released under this agreement.

4. I understand that I can refuse to sign this agreement. If I have questions about this agreement or uses and disclosures of my health information at UTMG, I can contact the UTMG Privacy Officer at 66 North Pauline Street, Suite 101, Memphis, TN 38105; (901) 448-6936.

Signature of Patient or Personal Representative*

Printed Name of Patient or Personal Representative*

Date

*Relationship to Patient (if Personal Representative)

*If Personal Representative, the patient is unable to sign because (check one):

- Minor Incompetent Other (explain): _____

For Office Use Only

Date received _____ All complete Proof of I.D. Signed copy to patient

Received by (employee name): _____ Title: _____

Completed by (employee name): _____ Title: _____