RHEUMATOLOGY & OSTEOPOROSIS CENTER OF MEMPHIS, P.C.

AGREEMENT TO RELEASE MEDICAL INFORMATION

Patient Name: _____ Phone Number: _____

I hereby agree to allow the physicians and/or staff of Rheumatology & Osteoporosis Center of Memphis, P.C. to release laboratory or other diagnostic test results, medication or other medical information as indicated below.

Please initial all that you wish to apply

_____ Information may be left on home answering machine with telephone number listed above or on file in our office.

_____ Information may be left on work/office voice mail at the following telephone number: _____

_____ Information may be shared with the following individuals:
(List all that apply, please include relationship and telephone number)

_____

_____

_____

_____

I understand that this agreement will be kept in my medical file. I also understand that information concerning my medical care will only be given to individuals that are listed above. This will include appointment information, laboratory or other diagnostic test information, medication or other medical information. I understand that I may update this agreement at any time by completing a new form.

_____ _____
Signature Date

CLICK TO PRINT FORM

ROCM-5002