TENSAS & VIDALIA
COMMUNITY HEALTH CENTERS

MEDICAL RELEASE FORM

As required by the Health Insurance Portability and Accountability Act (HIPPA) of 1996, TVCHC may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the use and disclosure of protected health information described herein.

I, ___________________________________understand that the information contained in my

record is confidential. However, I give consent of ________________________________

At ___________________________________to release all of my records or information

concerning such records to **Tensas + Vidalia Community Health Centers.**

I understand that the document authorized to be released by me include, but are not limited to, family histories, reports of clinic findings and diagnosis, laboratory test, X-rays, reports of examination and/or evaluation, and any hospital admission or discharge records.

I understand that I may revoke this consent at any time except to the extent that action has been taken thereon. I further understand that this consent will expire upon___________(not to exceed six months) and cannot be renewed without my written consent.

Signature____

Signature of Witness______________________________________

PATIENT IDENTIFYING DATA

Name: First__________________________________MI____________Last____________________________

Address:_____________________________________City_______________State_________ZIP__________

SS#:____Birthdate:__________________________________

TENSAS & VIDALIA COMMUNITY HEALTH CENTERS

402 Levee Street	*St Joseph, LA 71366*	*Phone: 318.766.1967*	*Fax: 318.766.9090*
900 Carter St, Suite A	*Vidalia, LA 71373*	*Phone: 318.414.3020*	*Fax: 318.414.3021*

TENSAS & VIDALIA
COMMUNITY HEALTH CENTERS

MEDICAL RELEASE FORM

PATIENT NAME:

Address: Phone #:

SS#: D.O.B.

Name of Person/Organization to RECEIVE medical information:

Address: Fax:

Information to be released: *(Please check all applicable records to release)*

___All Records ___Immunization Records ___Other:

Name of Person/Organization to RECEIVE medical information:

Address: Fax:

Information to be released: *(Please check all applicable records to release)*

___All Records ___Immunization Records ___Other:

Name of Person/Organization to RECEIVE medical information:

Address: Fax:

Information to be released: *(Please check all applicable records to release)*

___All Records ___Immunization Records ___Other:

I understand that I may revoke this authorization at any time by notifying the healthcare provider in writing. The revocation will only be effective from the date it is recevied in this office and will not apply retroactively.

Patient/Guardian Print Name: Relationship:

Signature: Date:

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