



# 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

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