Release of Medical Information

Please complete this form in its entirety and return along with a copy of a government issued form of identification to:

Attn: Release of Information
365 Great Circle Rd.
Nashville, TN 37228
1-800-533-7052
Fax: 877-406-0907
Email: patientrequests@aegislabs.com

For Aegis Use Only:
□ Mailed □ Picked up □ Faxed □ Emailed
Date Received: _____
Date Processed: _____
Processed by: _____

Section A. PATIENT IDENTIFICATION

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Previous Name: _____ Last 4 Digits of Social Security #: _____

Patient Phone: _____

Clinic Name: _____ Physician Name: _____

Clinic Address: _____

I request and authorize Aegis Sciences Corporation to release medical information of the patient named above.

Section B. RELEASE RECORDS TO *(Where records should be sent)*

□ Mail
□ Pick up in person
□ Fax
□ Email

□ ***Same as above***

Name/Agency: _____

Address: _____City: _____ State: _____ Zip: _____

Phone#: _____ Fax#: _____

E-mail Address: _____

Section C. INFORMATION REQUESTED: (Fees may apply)

□ Lab results

- List specific date(s) of service requested: _____

□ Other information (*specify*): _____

Section D. PURPOSE OF RELEASE

□ Patient Care
□ Personal Use
□ Attorney/Legal Case
□ Appointment/Sharing with other health care provider as needed
□ Disability/Insurance Application/Claim
□ Other (*specify*): _____

Section E. AUTHORIZATION STATEMENT

I understand that my medical record may include information on diagnosis or treatment related to psychiatric or psychological conditions, drug or alcohol abuse, and acquired immune deficiency syndrome (AIDS) or HIV status. I agree that any information about such diagnosis or treatment may be released.

PLEASE CHECK THE STATEMENT BELOW THAT APPLIES

(You must check one): I do _____ do not _____ authorize this information to be released.

Section F. SIGNATURE OF PATIENT

I understand that:

- I may refuse to sign this authorization.
- Refusing to sign this authorization will not affect my treatment, payment, enrollment, or eligibility for benefits.
- I may take back (revoke) this authorization in writing, except for any actions already taken based upon it.
- I understand that this authorization will expire when the records are released for the request dated below. Any requests after this date will need a separate authorization.
- If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy rules and may be shared with others.
- Aegis is not required to interpret test results for patients and that I must contact my healthcare provider with questions about the test results.

By my signature below, I certify that I am authorized to receive the information requested.

Signature of Patient: _____ **Date:** _____

If you are NOT the patient but are signing on behalf of the patient, please complete the following:

Section G. PERSONAL REPRESENTATIVE

I, _____(print name), am the (check which apply)

□ Parent with Parental Rights
□ Court Appointed Guardian
□ Legally Appointed Healthcare Agent
□ Medical Power of Attorney
□ Power of Attorney with Right to See Medical Records

By my signature below, I certify that I have the required authority to receive the information requested and I understand the provisions in Section F above.

Representatives Signature: _____ Date: _____

Address: _____City: _____ State: _____ Zip: _____

Phone #: _____

You MUST attach proof of your authority to act on behalf of the patient as checked above.