

Hamsley Consulting
Dr. Jeffrey Hamsley, Sr.

155 N Main Street, Suite 101B
Collierville, TN 38017
hamsleyconsultin@bellsouth.net

Phone: (901) 286-4017
Fax: (901) 853-7454
Mobile: (901) 489-0691

**CONSENT AND AUTHORIZATION TO RELEASE INFORMATION OR
MEDICAL RECORDS UNDER THE PROTECTION OF FEDERAL LAW, TITLE
42, CFR CHAPTER II, PART II**

Name: _____ Sex: _____
 First Middle Last

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

Pursuant to Federal Guidelines concerning my right to confidentiality,

I, _____

Authorize _____ to release

My medical records to: _____

Name of specific person(s) or organization(s)

I specifically consent only to the release of information or medical records

Pertaining to: _____

Specific nature, reason for, and extent of info to be released

I understand that I may revoke this consent to release information any time. However, I also understand that any release which has been made prior to my revocation and which was made in reliance upon this authorization shall not constitute a breach of my right to confidentiality. Unless I revoke this authorization prior to such time, this authorization or release information shall expire when:

state date, event or condition or expiration

at which time no express revocation shall be needed to terminate my consent.

Patient's signature

Date

If the patient is either under age or has a guardian appointed by the court, this release must be signed by the patient's parent or guardian.

Parent or guardian's signature

Date

Witness

Date