Shaw Family Medical 112 W Peeler Ave

Phone: (662) 754-3301 Fax (662) 754-3304

# Covid-19 Medical Records Release

Patient Name: \_ DOB: Address: City State Zip Code\_ \_

Last 4 digits of SSN: Phone Number \_

# Purpose of Disclosure: Continuity of Care

Please “PRINT” and complete ALL sections to insure your request is processed in a timely manner.

FAX RECORD TO (Number): (662)754-3304

I authorize Shaw Family Medical to release or disclose Covid-19 test results to the Cleveland School District.

CheckmarkI understand that I may revoke the Authorization at any time prior to the expiration date or event, but that my revocation will have any effect on action taken of Shaw Family medical or its physicians, employees or agents before they received my revocation. Should I desire to revoke this Authorization, I must send written notice to Shaw Family Medical.

CheckmarkI understand that I am not require to sign this Authorization. Shaw Family Medical will not disclose my condition or withhold treatment, payment enrollment or eligibility for benefits on whether I provide this Authorization.

CheckmarkI understand that my records may be subject to disclosure by the recipient and may no longer be protected by federal privacy regulations. I understand that this Authorization does not limit Shaw Family Medical’s or its physicians, employees, or agents use or disclose my information for treatment, payment, or health care operations, or as otherwise permitted by law.

CheckmarkI authorize SFM to request records pertinent to my treatment from providers and other healthcare entities, as needed, within the time authorization is valid. This authorization will expire a year from date of signature.

Patient or Authorized Representative’s Signature: \_ Date:

Relationship to the patient if not signed by patient:

Witness Signature: \_ Date: