MADISON RIDGELAND MEDICAL CLINIC
INTERNAL MEDICINE

11 Professional Parkway
Ridgeland, MS 39157
601-856-2460 Fax: 601-856-5363

AUTHORIZATION AND REQUEST TO RELEASE
INFORMATION TO MADISON RIDGELAND MEDICAL CLINIC

PATIENT NAME: _____

ADDRESS: _____

DOB: _____ SS # _____-_____-_____

I HEREBY AUTHORIZE _____
(Name of Facility, Doctor, etc)

MAILING ADDRESS _____

TO RELEASE MY RECORDS TO: **Madison Ridgeland Medical Clinic**

INFORMATION TO BE RELEASED _____
(Limitations on date(s) or procedures)

If no limitations stated, I further authorize and request that you provide copies thereof with no limitations placed on dates, history of illness, and/or diagnostic information.

The information to be released is confined to the following:

___ Complete Medical Records
___Physician Progress Notes
___Laboratory Data
___Diagnostic Reports
___EKG
___Treatment Plans
___Physician Orders
___Hospital Records

The consent will expire 90 days from the date signed. I understand that I may revoke this authorization at any time, in writing to the Medical Records Department. The information authorized for release may include information which may be considered a communicable or venereal disease which may include but are not limited to diseases such as Hepatitis, Syphilis, Gonorrhea and HIV/AIDS.

Signature of Patient or Legal Guardian | Relationship to Patient | Date

Witness | Date