SHOALS
Family Medicine

Megan Bullard, M.D.
Jonathan Parker, D.O.

PATIENT NAME____

RELEASE

I authorize Shoals Family Medicine physicians and staff into release my medical records to the following individuals:

1. Name_________________________________ Relationship_________________________

   Phone_________________________________ Address_____________________________

2. Name_________________________________ Relationship_________________________

   Phone_________________________________ Address_____________________________

3. Name__________________________________ Relationship_________________________

   Phone_________________________________ Address_____________________________

I understand that information disclosed pursuant to this release may be re-disclosed by the authorized recipient and no longer protected by the privacy rules of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Signed______________________________________ Date _______________________________

If patient is a minor or unable to sign, the complete the following:

Patient is a minor _______, or is unable to sign because_______________________________________

Signed______________________________Relationship______________________Date______________

Witness____

Phone: 256-386-1308 Fax: 256-386-1438