

**NOTIFICATION OF PHYSICIAN-PATIENT RELATIONSHIP
TO VIEW ELECTRONIC MEDICAL RECORD**

TO: METHODIST HEALTHCARE – MEMPHIS HOSPITALS

- Germantown HIM fax: (901) 516-6778
- Le Bonheur HIM Fax: (901) 287 – 6108
- North HIM Fax: (901) 516-5294
- South HIM Fax: (901) 516-3734
- University HIM fax: (901) 937-3344

FROM:

(Print Patient’s Full Name)

Patient’s Address

Date of Birth

SSN

Please provide Dr. _____ and/or any other
(Print Physician’s Name)
physicians with the:

Name of medical practice

Address

Phone Number

with full access to all of my medical records maintained by Methodist Healthcare-
Memphis Hospitals to enable them to provide health care services to me and authorize
the following patient-provider relationship:

Outreach Physician: Relationship will expire 90 days after the encounter’s discharge date.

I also authorize access to Behavioral Health Information.

_____ Date: _____

Patient’s or Authorized Representative’s Signature

Witness Name*

Witness Signature

*Witness must be employee of Medical Practice/Clinic