

**RELEASE OF MEDICAL RECORDS**

**PATIENT NAME:**

**Patient DOB:**

The above mentioned patient was treated in your facility. We would appreciate your sending a resume of the clinical findings, treatments and copies of any surgical procedure notes and radiology reports. Please also indicate any pathology and / or laboratory results.

- |   |  |
|---|--|
| <input type="checkbox"/> Colonoscopy Report | <input type="checkbox"/> Pathology Report  |
| <input type="checkbox"/> EGD Report         | <input type="checkbox"/> Laboratory Report |
| <input type="checkbox"/> Operative Report   | <input type="checkbox"/> Radiology Reports |

**PATIENT AUTHORIZATION:**

I hereby authorize:

Name: _____	to furnish Name: _____
Address: _____	5653 Frist Blvd Suite 530
_____	Hermitage, TN 37076
Fax: _____	Fax: 615-885-1110
Phone: _____	Phone: 615-885-1093

***The healthcare provider must complete the following:***

1. What is the purpose of this disclosure? Medical records review for the purpose of consultation.
2. Will the healthcare provider requesting the authorization receive financial compensation of any kind in exchange for using or disclosing the health information described above? NO

***The patient or patient's representative must read and initial the following:***

1. I understand that my healthcare and the payment for my health care will not be affected if I do not sign this form. Initials \_\_\_\_\_
2. I understand that I may see and may receive a copy of the information described on this form if I asked for it and that I will receive a copy of this form after I sign it. Initials \_\_\_\_\_
3. I understand and agree that this authorizes the release of information concerning HIV testing or treatment of AIDS, AIDS-related conditions, drug or alcohol abuse, drug -related conditions, alcoholism and / or psychiatric or psychological conditions. Initials \_\_\_\_\_

***Must be completed for all authorizations:***

***The patient or the patient's representative must read and initial the following:***

1. I understand that this authorization will expire in one year from the date of signature.  
Initials \_\_\_\_\_
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing. Should I do so, this action will not have any affect on any actions taken by the providing organization before they received the revocation.  
Initials \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Patient's Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient or Patient's representative