REQUEST FOR MEDICAL RECORDS

1. PATIENT INFORMATION

_____

Name Address City State Zip

_____ (_____)_____ _____

Date of Birth Daytime Phone Previous Name

2. AUTHORIZES:

_____

Name of Healthcare Provider/Other

_____

Address

(_____)_____ (_____)_____

Phone Fax

3. TO DISCLOSE TO:

THE TOWN DOCTOR® PLLC

_____

Name of Healthcare Provider/Other

1633 W. Main Street Suite 901 Lebanon, TN 37087

_____

Address

(615) 547-6930 **(615) 547-6933**

_____ _____

Phone Fax

4. **DATE (S) OF INFORMATION TO BE DISCLOSED**: From_____ to _____ If left blank, information from the past 2 years is requested. (month/yr) (month/yr)

5. **INFORMATION TO BE DISCLOSED**:

_____ All medical records related to (specify condition, treatment, etc):_____
_____ All medical records:
_____ Radiology films/images (specify test): _____
_____ Specific records/information an follows:_____
_____

_____

6. **PURPOSE**: Further Medical Care

Signature of Patient/Legal Guardian_____Date_____