Midtown Healthcare
Chad James, FNP-C
1097 Weston Drive Ste 3
Mt. Juliet, TN 37122
P: 615-288-3267 F: 615-288-3269

Medical Records Release Authorization

I hereby authorize Midtown Healthcare to release or disclose my medical records as described below to the office or person(s) listed:

□ Released to myself for personal or other use

□ _____

Name of Office, Provider Name, Address, Phone #

Patient Name:_____ **DOB:**_____

Patient Address:_____

Phone # for patient if there are questions about release:_____

Purpose for disclosure:_____

□ **Mail Records to:** _____

_____

□ **Fax Records to:** _____

□ **Pick up the records (Please list any individuals who have permission to pick up the records on your behalf)**

_____**Relationship**_____

Initial:_____ I only want records generated by Midtown Healthcare.
Initial:_____ I only want the following dates or specified report(s) generated by Midtown Healthcare. _____

If you *DO NOT WANT* certain portions of your medical records released, please read this section carefully and mark the boxes for information you do not want released. Otherwise, your records will be released as specified above.

I authorize Midtown Healthcare and any employees and/or agents to release the information specified to the organization, agency, or individual named on this request with the exception of:
□ Substance abuse (if any)
□ Psychological or Psychiatric conditions (if any)
□STD's (if any)

I understand that this information shall be in effect for 180 days following the date of signature. However, I understand that this authorization may be revoked at anytime by giving written notice to Midtown Healthcare.

Patient Signature (or Legal Representative)_____ Date_____

Print Name of Patient (or Legal Representative)_____ Date_____

Witness Signature_____ Name of Witness_____