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

Medical Request for Records Authorization

I hereby authorize _____ ← PLEASE LIST FACILITY AND/OR PROVIDER WE ARE REQUESTING RECORDS FROM.
to release or disclose my medical records as described below to Midtown Healthcare.

Patient Name:_____ **DOB**:_____

Patient Address:_____

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

Purpose for disclosure:_____

□ **Mail Records to:** 1097 Weston Dr., Ste. 3
Mt. Juliet, TN 37122

□ **Fax Records to:** 615-288-3269

□ **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 _____.
Initial:_____ I only want the following dates or specified report(s) generated by _____. _____

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 _____ 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 _____.

Patient Signature (or Legal Representative)_____ Date_____

Print Name of Patient (or Legal Representative)_____ Date_____

Witness Signature_____ Name of Witness_____

OFFICE USE ONLY:

Facility Phone #:_____

Facility Fax #:_____

Faxed Release on: _____ **Initials:**_____

Received Records on:_____ **Initials:**_____