North Main Medical

N.Main Street
Crossville, TN 38555
931-644-5423
931-337-0155 Fax

RELEASE OF MEDICAL RECORDS

PERMISSION TO RECEIVE OR SEND RECORDS

I, ______________________, with a date of birth, ________________________, give my permission to receive/send my records to (provider's name) ______________________________so that he/she can better understand my condition and help me.

REQUESTING RECORDS FROM:

Name of Provider/Practice____
Fax Number ________________Phone Number________________________
Address____

Types of records that we are requesting:

□Any and all types of records you have for patient

□Doctors visit notes
□Emergency Room notes
□Urgent care notes
□History and Physical
□Operation or procedure notes
□Clinic notes
□Pathology reports
□Doctors' orders
□Nurses orders
□Discharge Summary
□Lab reports
□Radiology Reports
□Consultations
□other__________________________

Records with in the following dates:

□All records for this patient
□Records dated between ___________________and ______________________

Patient's Signature__________________________Date_____________________

Authorized Witness Signature ______________________Date________________