4091 Mallory Lane
Suite 118
Franklin, TN 37067
Phone: (615) 791-9784
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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name ______________________ **Social Security Number** ______________________

D.O.B. ______________________

We are requesting medical records for the patient named above from:

Doctor:______________________**Phone #:** ______________________

Fax #: ______________________

☐ **I, the undersigned, authorize you to furnish a copy of my medical records to Cool Springs Family Medicine.**

☐ **I, the undersigned authorize Cool Springs Family Medicine to furnish a copy of my medical records to ______________________.**

I authorize Cool Springs Family Medicine to furnish and/or release my information necessary to insurance carriers concerning my illness and treatments, to process my insurance claim acquired in the course of my examination or treatment, to allow a photocopy of my signature to be used to process my insurance claim for the period of lifetime. This order will remain in effect until revoked by me in writing.

Signature of Patient or Parent/Guardian ______________________ **Relationship to Patient** ______________________ **Date** ______________________

Witness Signature ______________________ **Date** ______________________