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Cool Springs Family Medicine

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name _____ D.O.B. _____ Social Security Number _____

Address _____ Telephone _____

I, the undersigned, authorize you to furnish a copy of my medical records

☐ to Cool Springs Family Medicine ☐ to: _____

We are requesting medical records, for the patient named above, be sent

TO / FROM (please circle one) the doctor named below:

Doctor Name: _____ _____
First Last

Specialty: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____

____ I acknowledge and hereby consent to such, that the released information may
Init contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information

I, the undersigned, have read the above and authorized the staff of the disclosed facility named to disclose such information as herein contained. I understand that this consent may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it. I understand that re-disclosure of this information to a party other than the one designated above is forbidden without additional authorization on my part. This facility is released and discharged of any liability and the undersigned will hold the facility harmless, for complying with this "Authorization for Release of Medical Information." This order will remain in effect until revoked by me in writing.

_____ _____ _____
Signature of Patient or Parent/Guardian Relationship to Patient Date

PLEASE RETURN A COPY OF THIS FORM WITH RECORDS