



2690 Madison Street, Suite 130
 Clarksville, TN 37043
 Phone (931) 245-1701
 Fax (931) 245-1720

This form is giving Elite Primary Care permission to release records to another party

PATIENT REQUEST FOR MEDICAL RECORDS

(All sections must be completed)

DATE: _____

Patient Name: _____ Date of Birth: _____

I hereby authorize: Elite Primary Care and its physicians employees and agents to release or disclose to the below-named recipient all of my medical records including any specially protected records such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia, sexually transmitted disease, or HIV/AIDS infection.

I hereby authorize the release of medical records to:

Provider: _____

Address: _____

Phone: _____ Fax: _____

Purpose of disclosure: Changing PCP Moving out of town Other: _____

The authorization will expire on: _____

Date or Event may not exceed one year

This request and authorization applies to:

_____ All medical records

_____ Health care information relating to the following treatment, condition, or dates of treatment:

_____ Specific records to be released (eg. Labs, imaging reports, other):

If you DO NOT WANT certain portions of your medical records released, please initial the box for the information you do not want released.

_____ Substance abuse _____ Psychological or psychiatric treatment _____ HIV/AIDS/STD

Form and format of information: Paper Copy CD E-mailed (encrypted)

Note: If you would like us to send information over email unencrypted, this increases the risk that the information could be read by an unauthorized third party.)

Information will be: Mailed Picked-Up

I understand I have a right to revoke this authorization by written notification to the Privacy Officer, except to the extent it has acted in reliance thereon before notice of revocation. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure which may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization. I understand that I can refuse to sign this authorization and the above-named office may not condition treatment on my signing of this authorization.

Signature of Patient or Authorized Representative

Date Signed

Relationship to Patient

Fees for Medical Record Copies

Postage fee PLUS \$20.00 for medical records 40 pages or less in length & \$.25 per page over 40 pages

Paid:

Released date/method: