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

DATE: ________________________________

(All sections must be completed)

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: