Physicians Quality Care, PLLC

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION (PLEASE PRINT):

NAME: ____ DATE OF BIRTH: ___________________

SOCIAL SECURITY NUMBER: ____

ADDRESS: ____

CITY: ______________________________________ STATE: ___________ ZIP CODE: _________________

RELEASE MY MEDICAL RECORDS FROM:

Physicians Quality Care
2075 Pleasant Plains Ext.
Jackson, TN 38305
Phone: (731) 984-8400
Fax: (731) 984-8305

TO:

NAME: ______________________________

TEL: ________________________________

FAX: ________________________________

Please send medical records no later than: _________________________________

Please release a copy of all my medical records, including but not limited to, progress notes, operative notes, laboratory results and diagnostic tests.

BY MY SIGNATURE I AUTHORIZE RELEASE OF MEDICAL RECORDS

Patient/Guardian: ____ Date: ______________