Release of Medical Records

Request and Consent for Release of Medical Information or Records

First Name: ____________________________ MI: ____ Last Name: _________________________________

Maiden Name: _________________________________

Phone Number: _____________________ Date Of Birth: ___/___ / ___ SS# ________________________

Address: ____

Name of Physician / Hospital: ____

Street Address: ____

City: ____ ST: ____ Zip: __________

Records / Information Requested: ____

I hereby authorize: _________________________________ to release any and all medical information to:

- ☐ Belle Meade
- ☐ Brentwood
- ☐ Briarville
- ☐ Cool Springs
- ☐ Hendersonville
- ☐ Hermitage
- ☐ Mount Juliet
- ☐ Murfreesboro
- ☐ Nashville I Charlotte
- ☐ Saint Thomas I Midtown
- ☐ Saint Thomas I West
- ☐ Smyrna

My signature indicates that all information reflected on this form is true and accurate.

Patient Signature: ____ Date ______/______/______

Front Desk Initials: _____________

Premier Radiology

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