226 Jackson Meadows Drive, Hermitage, TN 37076
Office: (615) 874-3422 | Fax: (615) 874-3465
health@colefamilypractice.org

RELEASE OF MEDICAL RECORDS AUTHORIZATION

Patient Name: _____ **Date of Birth:** _____

Requested records from:

Office Name: _____

Provider Name: _____

Office Number: _____

Please send most recent office notes, x-ray reports, labs, procedures, and medication list to our office.

Other:

_____

_____

I understand no information may be disclosed by either agency to any individual or agency unless by written consent. I give my consent freely and voluntarily.

_____ _____

Patient (or Responsible Party) Signature Date

This authorization expires on _____ - if blank, then 90 days after date of signature