



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#: _____

Name of Physician / Hospital: _____

Street Address: _____ City _____ ST: _____ Zip _____

Records / Information Requested: _____

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

- PREMIER RADIOLOGY , 28 White Bridge Pike, Ste. 111, NASHVILLE, TN 37205
- PREMIER RADIOLOGY PAIN MANAGEMENT CENTER , 28 White Bridge Pike, Ste.104, NASHVILLE, TN 37205
- HERMITAGE IMAGING CENTER, 5045 Old Hickory Blvd, Ste.100 Hermitage, TN 37076

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

Patient Signature _____ Date ____ / ____ / ____

Front Desk Intials _____