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: _____/_____ / _____

Last 4 Digits of Social Security: _____

Address: _____

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 | MIDDLE TENNESSEE IMAGING

ATTENTION: Healthmark Group
28 White Bridge Pike • Suite 111 • Nashville, TN 37205

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

Patient Signature: _____ Date _____/_____/_____

Front Desk Initials: _____

You can submit this form via fax at 615.301.0193

If you have any questions, please call 800.659.4035 for assistance.

Ascension Saint Thomas | Premier Radiology

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