

NORTH CLARKSVILLE MEDICAL CENTER
351 DOVER ROAD
CLARKSVILLE, TENNESSEE 37042
TELEPHONE 931-552-4495 FAX 931-552-1944

AUTHORIZATION FOR MEDICAL RECORDS RELEASE
PICTURE IDENTIFICATION IS REQUIRED IN ORDER TO RELEASE OR PICK UP RECORDS. IF YOU ARE
SENDING SOMEONE ELSE TO PICK UP, PLEASE PROVIDE A WRITTEN STATEMENT AND INFORM THEM THEY
MUST HAVE PROPER PHOTO IDENTIFICATION

DATE REQUESTED _____

PLEASE INDICATE IF YOU WANT RECORDS RELEASE TO OR FROM

PLEASE RELEASE MEDICAL RECORDS **TO OR FROM** (PLEASE CIRCLE ONE) DR. RAMON J. AQUINO AT
NORTH CLARKSVILLE MEDICAL CENTER

PATIENT'S NAME: _____
(LAST) (FIRST) (MIDDLE)

OTHER NAMES RECORDS MAY BE LISTED UNDER: _____

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

YOUR CURRENT ADDRESS: _____

IF MOVING PLEASE PROVIDE NEW ADDRESS: _____

TELEPHONE NUMBER: () _____
(AREA CODE) (TELEPHONE NUMBER)

REASON FOR RELEASE OF MEDICAL RECORDS (CHECK ONE OR WRITE IN REASON UNDER OTHER)

INSURANCE REQUEST _____	PERSONAL REQUEST _____
ATTORNEY REQUEST _____	SPECIALIST REQUEST _____
GOVERNMENT AGENCY REQUEST _____	CHANGING PRIMARY PROVIDER _____
OTHER _____	REASON FOR CHANGE: INSURANCE REASONS _____
	PROBLEM: _____

PLEASE ASK THE FRONT DESK STAFF FOR COMPLAINT FORM IF LEAVING OUR CARE DUE TO A PROBLEM (YOU DO NOT HAVE TO IDENTIFY YOURSELF ON THE FORM AND YOU MAY MAIL THIS FORM TO OUR OFFICE LATER IF YOU PREFER)

SIGNATURE: _____ DATE _____

WITNESS SIGNATURE: _____ DATE _____

(PLEASE NOTE ONLY THE PERSON THE RECORDS ARE FOR CAN SIGN UNLESS OTHER PARTY PRESENTS POWER OF ATTORNEY OR OTHER OFFICIAL AUTHORIZATION FORM)

1 YEAR _____ 2 YEARS _____ 5 YEARS _____ COMPLETE CHART _____
SPECIFIC DATES OF SERVICE FROM _____ TO _____

PATIENT WILL PICK UP _____

NAME OF PHYSICIAN/ ATTORNEY/ GOVERNMENT AGENCY/ OTHER WHERE RECORDS SHOULD BE **SENT TO OR RELEASED FROM: (PLEASE CIRCLE)** _____

ADDRESS RECORDS TO BE **SENT TO OR RELEASED FROM: (PLEASE CIRCLE)** _____

TELEPHONE: () _____ FAX: () _____

PLEASE NOTE THAT STATE AND FEDERAL LAWS ALLOW FOR OUR OFFICE TO CHARGE FOR COPIES OF MEDICAL RECORDS. STATE AND FEDERAL ALLOWABLE IS \$20.00 FOR THE FIRST 40 PAGES AND 25 CENTS PER ADDITIONAL THIS IS FOR ANY MEDICAL RECORDS OTHER THAN WORKER'S COMPENSATION. TWO SIDED PAGES COUNT AS TWO PAGES. WE MAY ALSO CHARGE FOR POSTAGE IF IT IS NECESSARY TO MAIL THESE RECORDS. THIS FEE IS DUE AT THE TIME YOU SIGN THIS RELEASE FORM. IF YOU ARE LEAVING OUR PRACTICE THE BALANCE OF YOUR ACCOUNT IS DUE AT THE TIME YOUR RECORDS ARE RELEASED. IF YOU DO NOT PICK UP YOUR RECORDS YOU ARE STILL RESPONSIBLE FOR THE CHARGE. **REFUSAL TO PAY FOR COPIES OF YOUR MEDICAL RECORDS OR YOUR ACCOUNT BALANCE WILL RESULT IN YOUR ACCOUNT BEING SENT TO OUR COLLECTION COMPANY OR ATTORNEY. THIS RELEASE WILL EXPIRE ONE YEAR FROM DATE OF AUTHORIZATION OR UPON REQUEST OF PATIENT OR GUARDIAN.**

PLEASE INITIAL THAT YOU ARE AWARE THAT THERE MAY BE A CHARGE FOR YOUR MEDICAL RECORDS _____ (INITIALS)

DATE OFFICE RELEASED RECORDS _____
DATE OF NOTIFICATION OF PATIENT IF DIFFICULTY LOCATING RECORDS _____ COPY TO CHART _____