FAMILY MEDICINE WEST OF WARTBURG

1236 Knoxville Hwy Suite 500
PO Box 308
Wartburg, TN 37887
(ph) 423-346-5566 opt. 1 (fax) 423-346-4629

Please fill out each section in its entirety. If you **do not** have the **full address** or **phone number and fax number**, please call back with the information.

Patients Name: _____

SSN: _____-_____-_____ **DOB:**_____

Physician to **Provide** Records:

Address: **Family Medicine West of Wartburg**
1236 Knoxville Hwy Suite 500
PO Box 308
Wartburg, TN 37887
Ph: 423-346-5566 opt. 1 Fax: 423-346-4629

Person/Facility to **Receive** Records:

Name: _____

Address: _____

_____

Phone: _____ Fax: _____

☐ Please check here if you would like to pick up your records. **There is a minimum cost of $25($25 for the first 40 pages and $0.25 cents per page after 40 pages) if you choose to pick up your records. We may only take a credit/debit card or cash if you pick up your records. The receiving of records may take up to 48 hours to process after receiving a signed medical release form.**

If the person or entity receiving this information is not a healthcare provider or health plan covered by Federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations. Patient may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits. You may inspect or copy the protected health information to be used or disclosed under this authorization. For protected health information created as part of a clinical trial, your right to access is suspended until the trial is completed. Finally, you may revoke this authorization at any time. Your notice will not apply to actions taken by the requesting person/entity prior to the date they receive you request to revoke authorization.

_____ _____
Patient Name (print) Person Authorized to sign

_____ _____
Patients Signature Authorized Signature

Date: _____ Relationship: _____