MEDICAL RECORDS RELEASE FORM

Mt. Juliet HEALTH & WELLNESS

By signing this form, I authorize the release of confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

Patient Name: _____ Date of Birth: _____

The information you may release subject to this signed release form is as follows:

- ☐ Complete Records
- ☐ History & Physical
- ☐ Progress Notes
- ☐ Care Plan
- ☐ Lab Reports
- ☐ Radiology Reports
- ☐ Pathology Reports
- ☐ Medication Records
- ☐ Operative Reports
- ☐ Hospital Reports
- ☐ Other: _____

Requesting the release of my protected health information:

From : _____

Phone: _____ Fax: _____

Release To: Mt. Juliet Health and Wellness, LLC
1097 Weston Drive Ste. B
Mt. Juliet, TN 37122
Fax: 615-288-4133 ***DO NOT FAX MORE THAN 10 PAGES-Please mail.***
Phone: 615-553-5002

The purpose/reason for this release of information is as follows:

_____

_____ _____

Patient Name Signature of Patient or Representative

_____ _____

Date Relationship to Patient