

Physicians Quality Care, PLLC

Jackson Location

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION (PLEASE PRINT):

NAME: _____ DATE OF BIRTH: _____

SOCIAL SECURITY NUMBER: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

RELEASE MY MEDICAL RECORDS FROM:

NAME: _____

TEL: _____

FAX: _____

TO:

Physicians Quality Care
2075 Pleasant Plains Ext.
Phone: (731) 984-8400
Fax: (731) 984-8305

Please send medical records no later than: _____

Please release a copy of all my medical records, including but not limited to, progress notes, operative notes, laboratory results and diagnostic tests.

BY MY SIGNATURE I AUTHORIZE RELEASE OF MEDICAL RECORDS

Patient/Guardian: _____ Date: _____