Physicians Quality Care, PLLC

Milan 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
15463 South First St.
Milan, TN 38358
Phone: (731) 686-8688
Fax: (731) 723-1199

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: _____