HITCHCOCK
FAMILY MEDICINE

Authorization to Request Medical Records

PATIENT INFORMATION:
Name (print) DOB SSN

_____ _____ _____

INFORMATION TO BE RELEASED FROM:
Name of facility or provider

_____
Address

_____

INFORMATION TO BE SENT TO:

Hitchcock Family Medicine, PLLC
5104 Hixson Pike
Chattanooga, TN 37343
(ph) 423-763-1942
(fax) 423-763-1842
info@hitchcock.md
Upload as .pdf to https://tinyurl.com/HFMrecords

INFORMATION TO BE RELEASED: (check one)
_____ All medical records
_____ Specific information (please specify):

PURPOSE FOR WHICH THE DISCLOSURE IS BEING MADE:
Continuing Medical Care

PATIENT AUTHORIZATION:
I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

MY RIGHTS:
I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

Signature: _____ Date: _____
(Patient, guardian, or Authorized representative)

This authorization will expire one year from the date signed, unless otherwise noted or cancelled.