Medical Records Request

Patient Name:_____

Patient Date of Birth:_____ Patient SS# _____

( ) Entire Chart: from:_____ to_____

( ) Other: _____

Check your Doctor:

☐Terry Lowe, MD
☐Selena Clearman, FNP
☐Wayne Hughes, MD
☐Stephen Lambert, MD
☐Melanie Lindsey, MD
☐Chad Diamond, DO
☐Jason Lindsey, DO
☐Kevin Clearman, FNP
☐David Hibbets, DO
☐Michael May, MD

I authorize **The Family Practice Clinic (601) 268-5058 Fax**

☐ to release **my medical records to:** ☐ to receive **my medical records from:**

(Name:)_____

(Address)_____

_____

(Phone)_____ (Fax) _____

☐ Email my records to me: _____

I understand that medical records may include information regarding a sexually transmitted disease, AIDS, or HIV infection as well as information about behavioral health services or treatment for alcohol and drug abuse.

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and will not apply to information already released under this authorization. Unless otherwise revoked, this authorization is effective for six months from the date signed.

Signature of Patient: _____ **Date**:_____

Witnessed By: _____