SUMMIT ENT ASSOCIATES

5653 FRIST BLVD., SUITE 231 * HERMITAGE, TN 37076 * PHONE: 615.872.0922 * FAX: 615.885.8059
KENT R. MURPHY, MD.

Authorization for Release of Medical Records

Patient Information

Patient Last Name ___________________________ First Name ______________________________ MI ________

Street Address ____ Apt # _______

City ________________________________ State ________________________________ Zip ______________

Telephone ____ Date of Birth _____________________________

Information Requested

_____ Complete Medical Records   _____ Audiogram   _____ Radiology Reports

_____ Laboratory Reports   _____ Progress Reports   _____ Pathology Reports

Records Released From:

Name – (i.e. Heath Facility, Physician…) ____

Street Address ____

City ___________________________________ State ________________________ Zip ___________________

Phone # ______________________________________ Fax # ____

Records Released To:

Name – (i.e. Heath Facility, Physician) ____

Street Address ____

City ____________________________________ State ________________________ Zip ____________________

Phone # ____ Fax # _____________________________________

I authorized release of my medical records in accordance with the specification listed above. I understand that I have the right to inspect and receive a copy of the disclosed material.

Signature of Patient ____ **Date** ________________
(If 18 years of age or older)

Signature of Parent/Guardian ____ **Date** ________________