Medical Records Request

Patient Name: ________________________________ Patient DOB:______________

Patient SS# ______________________________

( ) Entire Chart: from: _____________________________________

( ) 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) __________________________

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 any disclosure of information carries with it the potential for re-disclosure and that the information ten may not be protected by confidentiality rules. I also understand that the degree of confidentiality can be modified with a facsimile transmission and that the Practice and Physician are not responsible for records once they have been transmitted. **I choose to have my records faxed _________ (please initial)**

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 Parent:________________________________ **Date**:________________

Witnessed By: ____