Medical Record Request

Family Practice After Hours Clinic
110 Millsaps Drive
Hattiesburg MS 39402
Phone - 601-261-5710, Fax - 601-268-5058

PATIENT NAME: _____ PATIENT DOB: _____

( ) Last 1 year of office notes, labs/xrays, mammogram/pap smear/colonoscopy (if applicable).

( ) Other (please specify) - _____

Check your Provider:

( ) Terry Lowe, M.D.
( ) Stephen Lambert, M.D.
( ) ShaWanda Suber, M.D.
( ) Selena Clearman, FNP
( ) Chad Diamond, D.O.
( ) Leigh Copeland, M.D.
( ) Kevin Clearman, FNP
( ) _____

I authorize The Family Practice After Hours Clinic:

( ) **to release my medical records to:** ( ) **to receive my medical records from**:

Name: _____

Address: _____

_____

Phone: _____ Fax/Email: _____

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 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 Provider 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 one year from the date signed.

Records released to Patient - *Email - no cost. *Paper copy - Cost $20.

Signature of Patient/Parent/Guardian: _____**Date**: _____

Witnessed by: _____