Please fax completed forms to (629) 255-4000 or via mail to 222 22nd Avenue North, Suite 100 | Nashville 37203
I hereby authorize Heritage Medical Associates to release my medical records as described below:

Patient Information

Name _____ Other Names _____

Address _____ City _____

State _____ Zip _____ Phone _____ Birthdate _____

Release Information To

Name/Facility _____ Attention _____

Address _____ City _____

State _____ Zip _____ Phone _____ Fax _____

Email Address for Record Delivery: _____

There may be a fee for collecting your records. If so, an invoice will be provided to you through email. Behavioral Health records will be mailed to the address above. Other records will be provided as an Adobe PDF file on BACTES Mail Express portal. You will receive an email from Bactes.com containing instructions for accessing the records. If you do not retrieve your records within 30 days, they will be deleted.

Purpose of Request □ Personal □ Treatment □ Legal □ Insurance □ Transfer

Information to be Released *If you fail to specify, a 1 year abstract will be provided.*

☐ Please release a **1 year abstract** of my records (includes most recent notes, labs, procedures & testing)	☐ **Date range**: _____ ☐ Progress Notes ☐ Radiology Reports ☐ Labs ☐ Operative Reports ☐ Injections ☐ Physical Therapy ☐ Billing Statement ☐ Other: _____	Pursuant to HIPAA 45 CFR, 164.524, we reserve the right to charge a reasonable cost-based fee for producing and mailing the copies. At no time will the cost-based fees exceed Tennessee law. **Note, there is no charge for records being released to another healthcare provider.**
☐ Please release a **2 year abstract** of my records (office notes, labs, procedures & testing, up to 2 years)		
☐ Radiology Disk		

Authorization to Release Protected Healthcare Information

I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information. I understand that: I may refuse to sign this authorization and that it is strictly voluntary. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. **Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____.** *If I do not specify expiration this authorization will expire in 90 days.* If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. I can request a copy of this form after I sign and date it.

Patient or Authorized Representative's Signature: _____

Relationship to the Patient (if applicable): _____ Date _____

** For non-emancipated minors under the age of 18, a parent or guardian must sign release form. If patient is unable to sign, a copy of the legal documentation for patient's representative must be supplied with a copy of this form.*