

MidState  
PULMONARY

Breathe. Sleep. Heal.

# MEDICAL RECORDS RELEASE

Physician to provide records: \_\_\_\_\_

Fax: \_\_\_\_\_ Phone: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

Address: \_\_\_\_\_

**PHYSICIAN TO RECEIVE RECORDS:**

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> Mark D. Peacock, M.D.    | <input type="checkbox"/> Richard Tyson, M.D.   | <input type="checkbox"/> Jordan Phillips, M.D.  | <input type="checkbox"/> Victor Kha, DO, FCCP |
| <input type="checkbox"/> Chace T. Carpenter, M.D. | <input type="checkbox"/> Jason Pritchett, M.D. | <input type="checkbox"/> Benjamin Ferrell, M.D. |   |
| <input type="checkbox"/> Stephen A. Capizzi, M.D. | <input type="checkbox"/> Thomas Atwater, M.D.  | <input type="checkbox"/> Michael Burk, M.D.     |   |

**PLEASE FAX RECORDS TO: 615-284-5385**

**RELEASE THE FOLLOWING RECORDS:**

**Initial Below**

1. Only a Portion of the records maintained, specify below:

_____	_____
_____	_____
_____	_____
_____	_____

2. All Medical Records at this Facility: \_\_\_\_\_

**Please check any information below, you chose not to be released from this facility:**

- Substance Abuse       AIDS/HIV, if any       Psychological or Psychiatric Conditions

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

\_\_\_\_\_ **Date:** \_\_\_\_\_

***Signature of authorized person signing on patient's behalf***

**Relation to Patient:** \_\_\_\_\_

Revised 6.2.2022