Medical Record Request Form

Patient Information:

Full Name: ______________________________ Date of Birth: _________________________________

Phone Number: _________________________ Email Address: ________________________________

Record Request Information:

I authorize **Music City Primary Care** to release my medical records to:

Name of Recipient: ______________________

Address: ____________________________ City: _____________ State: ________ Zip Code: _________

Phone Number: _________________________ Fax number: ________________________________

Records to be Released (check all that apply):

- ☐ Entire Medical Record
- ☐ Office Visit Notes
- ☐ Lab Results
- ☐ Imaging Reports
- ☐ Medication History
- ☐ Immunization Records
- ☐ Other (please specify): _________________________________

Purpose of Request (check one):

- ☐ Continuation of Care
- ☐ Personal Records
- ☐ Legal/Court Proceedings
- ☐ Insurance/Disability Claims
- ☐ Other (please specify): _________________________________

Patient Signature: _________________________________ Date: ____________________

Please return this form to Music City Primary Care via:

- Secure Online Submission: info@musiccityprimarycare.com
- Mail: 2201 Murphy Ave, Suite 215, Nashville, TN 37203
- In Person: 2201 Murphy Ave, Suite 215, Nashville, TN 37203

Please contact us at **615-712-8073** for questions or assistance.