Medical Records Release

CONSENT TO RELEASE and/or RECEIVE CONFIDENTIAL INFORMATION

I, ____ DOB: ________________

Patient Name (Please Print)

Hereby authorize:

Charles Marable, M.D.
Marable Personal Healthcare, PLLC
106 Mission Court
Suite 702A
Franklin, TN 37067

Phone: (615) 771-8181
Fax: (615) 771-8180

O to release to: O to receive from:

____
Physician's Name and Facility

____
Address City State Zip

____
Phone Fax

The information below regarding my medical care:

- O Progress Notes
- O History and Physical
- O Discharge Summary
- O Lab Results
- O X-Ray Reports
- O EKG / Cardiac Reports

O Other: ____

USES: Marable Personal Healthcare, PLLC or Charles Marable, M.D. may use the records and information to provide me with healthcare goods and services

DURATION: This authorization will expire one year from the date below, unless otherwise noted.

RESTRICTIONS: I understand that Marable Personal Healthcare, PLLC and Charles Marable, M.D. may not further use or disclose the medical records and information unless another authorization is obtained from me, or unless such use or disclosure is specifically required or permitted by law.

Signature of Patient (or legal guardian): ______________________________ Date: ____________