My House Clinic

MEDICAL RECORDS RELEASE FORM

Office: _____

Attention: _____

Address: _____

City: _____State: _____ Zip: _____

Phone: _____ Fax: _____

Client Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Phone: _____

I authorize the release of my medical records and other healthcare information including chart notes, lab results, reports, correspondence, and any other written information concerning my health and treatment. Also, including Hepatitis, HIV Infection, HIV-related illness, or AIDS, mental health, Alcohol, drug usage, and treatment information, along with all other STI Information, Pathology, Lab, and Office visits to be mailed or faxed to the following medical facility:

My House Clinic
442 Metroplex Drive
Bldg D, Suite 200
Nashville, TN
37211
Ph: (615) 499-7406
Fax: (615) 466-7412

Client Signature: _____ Date: _____