Reservoir Family Medical Clinic

1679 Old Fannin Road ~ Suite E ~ Flowood, Mississippi 39232
Phone (601) 992-6511 ~ Fax (601) 992-5684
Dr. Charles N. Crenshaw, III, MD

Request for Patient Records

Patient name

Date of birth | Social security number

Requesting records from:

Provider / facility

Address

Phone | Fax

I authorize and request the disclosure of the full and complete protected health information to Reservoir Family Medical Clinic for review, evaluation, and/or further medical treatment.

☐ Complete medical record	☐ Consultation reports	☐ Operative reports
☐ History & physical	☐ Imaging reports	☐ Laboratory test results
☐ Discharge summary	☐ Progress notes	☐ Other_____

For date(s) of service: _____

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), alcohol or drug abuse, and behavioral or mental health services.

I understand that I have a right to inspect and obtain a copy of my protected health information, excluding any psychotherapy notes or any information compiled in anticipation of use for any legal proceeding, any information not subject to disclosure under the C.L.I.A. of 1988, and certain other records.

I understand that I have the right to revoke this authorization at any time, except to the extent it has been released in reliance upon this authorization, and I understand that this information may be re-disclosed by the recipient and no longer be protected under the terms of this authorization.

Signature of patient or legally authorized representative | Name and relationship of representative

Witness signature | Date