**Date:** __________

**I am requesting that copies of my medical chart currently on file at:**

______________________________________________________________________________

**Name of your prior physician's practice or hospital**

______________________________________________________________________________

**Complete mailing address of your prior physician's practice or hospital**

**Phone**_________________________________________ **Fax**____________________________________________

**To be sent to:**

Montgomery Family Medicine
P.O.Box 240369 / 8190 Seaton Place
Montgomery, AL 36124-0396
Phone: (334) 396-9100 Fax: (334) 396-9110
www.MontgomeryFamMed.com

**Initial one please:**
_____Please send my most recent notes in chart.
_____Please send all information currently in my medical chart since this date: ____________

**Initial ALL that you agree to release.** Your initial IS NOT an admission that your chart contains this information:

_____You MAY include information about any sexually transmitted disease.
_____You MAY include information about any HIV infection or AIDS diagnosis.
_____ You MAY include information about abuse or treatment for alcohol or drug abuse.
_____ You MAY include any information about psychological, psychiatric or mental health diagnoses and/or treatment.

**Print Patient Name**: __________________________________________________________________________

**Patient SSN**: ____________________________________________ **DOB**: ________________________________

**New Physician:** **Elrod / Graves / Mathis / Hendon / Moore** **Your Contact Telephone Number:** _________________
Circle one

*Please provide **either** a complete mailing address **or** a fax number to your prior physician and **your** contact number so we can expedite your request.*

**Signature**: __________________________________________ Relationship to Patient: _________________
(Patient or Guardian)

***The following statements are required by law.**
Information released pursuant to this authorization is subject to redisclosure by the recipient and therefore the protection of this information can not be guaranteed by this facility.

You may revoke this authorization at any time, except when information has already been released pursuant to this authorization.

This authorization only permits the release of **one** copied set of the desired portion of your medical records. Additional sets of copies, even to the same recipient, will require a new authorization.