



SCENIC CITY	FAMILY PRACTICE
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RELEASE OF PROTECTED HEALTH INFORMATION (PHI) AUTHORIZATION REQUEST

Patient Information	Name: _____ Date of Birth: _____ Maiden/Other Names Known By: _____ Address: _____ Phone: _____
Previous Provider Releasing Records	Name: _____ Address: _____ Phone: _____ Fax: _____
Patient Authorization Signature	Sign Here: _____ Date: _____
Purpose of Release	<input type="checkbox"/> Medical Care <input type="checkbox"/> Other: _____
Information Requested	<input type="checkbox"/> Entire Record <input type="checkbox"/> Vaccine Record <input type="checkbox"/> Cardiology/Radiology <input type="checkbox"/> Mammogram <input type="checkbox"/> Other: _____ <input type="checkbox"/> Recent Hospital Visit <input type="checkbox"/> Recent Med Visit <input type="checkbox"/> Recent Lab Results <input type="checkbox"/> Recent Physical
Release Records To	Christopher B. Walls, DNP, NP-C Scenic City Family Practice 5720 Uptain Road Building 6100 Suite 4600 Chattanooga, TN 37411 t: 423.661.3600 f: 423.661.3602 e: scfptn@scfptn.com