Request to **Receive** Medical Records from a Third Party for Treatment Purposes

Patient's Name: _____ Date of Birth: _____

Please fax or mail this form as a cover sheet with the following records requested to:

Pediatric Associates of Davidson County, PC (PADC)

2201 Murphy Avenue, Suite 201

Nashville, TN 37203

via Facsimile to 615-327-4934

Requesting PHI release from:

Entity Name _____

Entity Address _____

_____

Entity Phone Number _____ Fax Number _____

Description of records requested:

____ All healthcare information history, immunization records, growth charts

____ Other: _____

HIPAA Privacy Rule (45 CFR Parts 160 and 164) - it is not required to obtain patient consent and/or signature before sharing records for treatment purposes.

Office Use Only

Type of ID Verified _____ Signature _____ Date _____

Date Requested: _____ Date Received: _____

Notes:

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