Release of Medical Records

Request and Consent for Release of Medical Information or Records

First Name: ____________________________ MI: ____ Last Name: _________________________________

Maiden Name: ____

Phone Number: ____ Date Of Birth: ______/______ / ______

Last 4 Digits of Social Security: ____

Address: ____

Name of Physician / Hospital: ____

Street Address: ____

City: ____ ST: ____ Zip: __________

Records / Information Requested: ____

I hereby authorize: _________________________________ to release any and all medical information to:

PREMIER RADIOLOGY | Ascension

ATTENTION: Medical Records RIS/PACS
28 White Bridge Pike • Suite 111 • Nashville, TN 37205

My signature indicates that all information reflected on this form is true and accurate.

Patient Signature: ____ Date ______/______/______

Front Desk Initials: _____________

You can submit this form via fax at 615.301.0193

If you have any questions, please call 615.239.2061 for assistance.

Premier Radiology | Ascension

Revised 1.13.2020