

**The Barfield Clinic**

2910B South Church Street, Murfreesboro, TN 37127

Phone: (615) 895-3600 Fax: (615) 895-0024

**RELEASE OF MEDICAL RECORDS  
FROM THE BARFIELD CLINIC, PLLC**

Date: \_\_\_\_\_

Name: \_\_\_\_\_

I hereby authorize The Barfield Clinic, PLLC to release my complete medical record; including medical history, lab reports, imaging reports, EKGs, and other information as may pertain to my treatment at this facility.

Receiving Agency

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Guardian Signature (if patient is a minor)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Social Security Number

\_\_\_\_\_  
Date of Birth

**NOTE: The following must be specified to be released. Unless noted, this information will not be released with your medical records.**

**Initial**

\_\_\_\_\_ **Drug/Alcohol Treatment**

\_\_\_\_\_ **HIV Treatment**

\_\_\_\_\_ **Psychiatric Treatment**

**This authorization expires 90 days from date of signature.**