

The Barfield Clinic

2910B South Church Street, Murfreesboro, TN 37127
Phone: (615) 895-3600 Fax: (615) 895-0024

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

Date: _____
Name: _____

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

Releasing Agency

Phone: _____ Fax: _____

Patient Signature

Date

Guardian Signature (if patient is a minor)

Date

Patient Social Security Number

Date of Birth

Please send records to:

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