FOR USE BY PATIENTS TREATED BY DR. DEANNA BROWN
PATIENT REQUEST FOR COPIES OF MEDICAL RECORDS
AND TRANSFER OF PATIENT CARE

In accordance with Tennessee Code Annotated Section 63-2-101, a patient or patient's authorized representative is entitled to receive a copy of the patient's medical records, or at the healthcare provider's option, a summary of such records, upon payment of the costs of reproduction, copying and mailing of such records. Pursuant to TCA Section 63-2-102, payment of the costs of reproduction, copying and mailing of records may be required by the healthcare provider prior to the records being furnished.

If you request a transfer of your medical records other than by electronic transfer, you must pay this cost prior to such transfer of your medical records. The cost for medical records is $20 for the first 5 pages and $.50 per page in excess of 5 pages. ***The practice has arranged for the transfer of medical records to Dr. Deanna Brown via electronic transfer. This electronic transfer is available only for medical records to be transferred to Dr. Brown. There is no charge for an electronic transfer of your medical records to Dr. Brown.***

The undersigned patient hereby requests that C. Rodney Susong, MD, PC (hereinafter the "Practice") furnish copies of the patient's medical records to (please initial the appropriate selection below):

____ the patient (copying charges will apply)

____ Dr. Deanna Brown via electronic transfer (no copying charges will apply)

____ the following person: _____ (copying charges will apply)

If you wish for our office to deliver to you or to any other person, a portion but less than all of your medical records, please contact our office to advise us what portion of your medical records you want us to deliver.

This request shall constitute patient's full, unconditional, and complete authorization for the Practice to so furnish all copies of the patient's medical records to the person selected above.

If a request is made for the Practice to transfer your records to any healthcare provider, then this request will operate as a notice to the Practice by you that the Practice is no longer to be considered your healthcare provider unless you specifically advise the Practice otherwise.

If you wish for us to mail your paper records to you or to the person selected above, please enter below the address to which you want the records mailed:

_____

_____

IF YOU REQUEST RELEASE OF YOUR MEDICAL RECORDS TO DR. DEANNA BROWN, DR. BROWN WILL BE RESPONSIBLE FOR YOUR FUTURE MEDICAL CARE UNLESS YOU SPECIFICALLY ADVISE THE PRACTICE OTHERWISE.

PATIENT'S SIGNATURE:

_____ _____
(Patient's signature) (Patient's printed name)

DATE: _____ _____(Patient's date of birth)

Susong Dermatology, ATTN: Medical Records, 2051 Hamill Rd, Suite 301, Hixson, TN 37343