

Acute Care Clinic, Inc

131 S Webb Ave Crossville, TN 38555 P: 931-484-5379 F: 931-484-5946
CHAD A CONATSER, M.D JILL K DENNEY, PA-C JOAN GARDNER, PA-C CHADRICK HULL, PA-C

Name: _____ DOB: _____
Phone: _____ SSN: _____
Address: _____
Email: _____

Insurance/Payment Status:

Primary Insurance Carrier: _____

Policy ID #: _____ Group #: _____

Secondary Insurance Carrier: _____

Policy ID #: _____ Group #: _____

Self-Pay: I am registering as a self-pay patient and accept financial responsibility at the time of service.

Preferred Provider: _____

Previous Provider: _____

Previous Provider Address: _____

Previous Provider Phone: _____ Last Date Seen: _____

Pharmacy Name: _____

Referred By: _____

Authorization for Transfer of Medical Records

From (Previous Facility/Doctor): _____

Phone: _____ Fax: _____

To (Receiving Facility): Acute Care, Clinic Inc. | Fax: 931-484-5946 | Phone: 931-484-5379

Records Requested

I hereby authorize the disclosure and transfer of my health history. Please transmit:

Standard Summary (Past 2 years of chart notes, labs, imaging, and vaccine history)

Complete Medical File (All available historical health records)

Specific Records: _____

Acknowledgement: I authorize the release of my protected health information to ensure continuity of care. I may revoke this in writing at any time. Once disclosed, federal privacy laws may no longer protect this data from re-disclosure, though the recipient remains bound by professional confidentiality.

Patient/Guardian Signature: _____ **Date:** _____

Internal Clinic Use Only

Packet Received/Reviewed By: _____ Date: _____ Time: _____ AM/PM

Photo ID Copied Insurance Card Copied CSMD Report Attached

Decision: Accepted Declined

Provider Signature: _____ Date: _____