Daybreak Treatment Center
2262 S. Germantown Rd.
Germantown, TN 38138
901-753-4300

Request for Medical Records

Date of Request: ____/____/____ Name of Requesting Party: ______________________________

Patient Name: ______________________________________ Date of Birth: _____/_____/_____

I authorize Daybreak Treatment Center to release medical records to the following person, facility, agency or school.

(Please provide the following information for the person, facility, agency or school to which you would like the records sent.)

Name: ____

Address: ____

City: ______________________________ State: ______________ Zip Code: ____________

Phone Number: ( ) ____________________ Fax Number: ( ) ________________________

Name: ____

Address: ____

City: ______________________________ State: ______________ Zip Code: ____________

Phone Number: ( ) ____________________ Fax Number: ( ) ________________________

____ _______/_______/_____

Signature (Parent or Legal Guardian) **Date**
(Patient-18 years or Older)

Charge for Medical Records:

No Charge ________ $25.00_______ Payment received on ________________