  
**RECEIPT OF PATIENT REQUESTED COPY OF MEDICAL RECORDS**

I hereby acknowledge that I have requested and have received a copy of my medical records from Medical Direct Care, PLC; 190 Hatcher Ln, Suite B, Clarksville, TN 37043.

This copy of my records contains the following information:

\_\_\_\_\_\_ All records

\_\_\_\_\_\_Hospital Stay

\_\_\_\_\_\_Hospital Discharge Summary

\_\_\_\_\_\_Immunizations Only

\_\_\_\_\_\_Laboratory

\_\_\_\_\_\_Operative Report

\_\_\_\_\_\_Pathology Report

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Signature of Patient Name of Patient (print) Date

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Signature of Witness Name of Witness (print)/Position Date