REQUEST FOR RELEASE OF MEDICAL RECORDS

PATIENTS NAME_____ DATE OF BIRTH_____

I hereby authorize the release of medical records of the above-named patient to:

_____

Name

_____

Address

_____

City State Zip

Copies of the complete medical record are requested unless otherwise noted below:

X-Ray Results

Lab Results

Specific Dates of Service: _____

Other: _____

I understand this consent can be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance on this consent.

The facility, its employees, officers, and attending physicians are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

_____ _____

Patient or Patient Representative Signature **Date**

400 Berywood Trail NW Suite B, Cleveland, TN 37312
Phone: 423-472-3201 Fax: 423-476-4949