TN PREMIER CARE

1924 Dutch Valley Drive
Suite 3
Knoxville, TN 37918
Ph: (865) 281-5922
Fax: (865) 766-5396

1907 West Morris Blvd.
Suite A300
Morristown, TN 37813
Ph: (423) 353-1390
Fax: (423) 353-1393

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

To: _____

Phone: _____

Fax: _____

You are authorized to release any and all medical records related to my medical condition and treatments that I may have had during the time I was there, to the above clinic.

Please release my last 6 months of records OR last 3 office visits, any MRI's/CT's that have been done within the last 3 years, or otherwise stated: _____

_____

_____ My initials here indicate authorization to all medical records requested.

A photocopy of this authorization shall have the same force and affect as an original. All prior authorizations are canceled.

I have executed this document _____ day of _____ 20___

NAME OF PATIENT: _____

ADDRESS: _____

CITY, STATE & ZIP CODE: _____

PATIENT'S PHONE #: (_____)_____-_____ DOB: ____/____/____ SS #: _____

CELL PHONE #: (_____)_____-_____

Signature of patient _____ Date: ____/____/____