3609 Outdoor Sportsman Place ● Kodak TN 37764 ● Ph: 865-281-5922 Fax: 865-766-5396

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

To:_____

Phone:_____ Fax:_____

You are authorized to release any and all medical records related to my medical condition and treatment that I may have had during the time period I was there to TN PREMIER CARE. All Medical Records, Reports, Labs, MRI's, CT's, X-Rays, etc. for the past six (6) months or otherwise stated.

_____

___ Initials here indicates authorization to release all medical records requested.

A photocopy of this authorization shall have the same force and effect as the original. All previous authorizations shall be canceled. I understand that my medical records may include information on diagnosis or treatment related psychiatric or psychological conditions, drug or alcohol abuse, acquired immune deficiency syndrome, AIDS or HIV status. I agree that my information about such diagnosis or treatment may be released.

I have executed this document on the _____ day of _____, 20_____

Patient Name: _____

Address: _____

Patient Phone #: _____ DOB: _____ SS#: _____-_____-_____

Patient Signature: _____ Date: _____