

To:

Hospital/HealthCare Provider

Street Address City State Zip

Phone / Fax

From:

Patients Name

Social Security Number

Date of Birth

I, _____, do hereby authorize and request the release of any and all medical record in your possession to be submitted via fax or mail to:

Andrew M. Douglass, M.D.
1344 Dowell Springs Blvd.
Knoxville, TN 37909
Fax (865)357-8346

The complete records will be necessary in order for our files to be satisfied. That includes but not limited to Progress notes, History and Physicals, treatments and prognosis, laboratory and test reports.

Patient Signature

Date