



# Knoxville Center for Dermatology & Plastic Surgery

9430 Parkwest Blvd. Suite 240, Knoxville, TN 37923  
Phone (865) 470-4127 FAX (951) 257-0143

## MEDICAL RECORD RELEASE AUTHORIZATION

PATIENT NAME: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Chart #: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Information Requested:  Office Notes  Surgical Reports  Lab/Pathology Reports  
 Imaging/Xrays/Mammograms  Photographs  All Records

### I Request that my information be released **FROM**:

Name: \_\_\_Dermatology Associates of Knoxville\_\_\_  
Address: \_\_\_939 E Emerald Ave. Suite 705\_\_\_ City: \_\_\_Knoxville\_\_\_ State: \_\_\_TN\_\_\_ Zip: \_\_\_37917\_\_\_  
Phone: \_\_\_(865) 524-2547\_\_\_ Fax: \_\_\_(865) 524-0224\_\_\_

I authorize the above physician to  release my medical records to  speak to/discuss  both release medical records and discuss medical information with the following office.

### I request that my information be released **TO**:

Name: \_\_\_Knoxville Center for Dermatology and Plastic Surgery\_\_\_  
Address: \_\_\_6408 Papermill Dr. \_\_\_ Suite 100\_\_\_ City: \_\_\_Knoxville\_\_\_ State: \_\_\_TN\_\_\_ Zip: \_\_\_37919\_\_\_  
Phone: \_\_\_(865) 470- 4127\_\_\_ Fax: \_\_\_(951) 257-0143\_\_\_

It is our policy that patient medical records will be given only to the patient unless specified above. This authorization does not expire unless revoked or terminated by the patient or the patients personal representative. **You may revoked or terminate this authorization by submitting a written revocation to Dr. Daniel Fowler, MD.** You may request this form from our office. Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. It may not be possible to ensure your right to the protection of the privacy of this information once Dr. Daniel Fowler discloses it to a party listed above. You may inspect or copy information used or disclosed under this authorization.

You may refuse to sign this authorization. If you refuse to sign this authorization, Dr. Daniel Fowler will not deny you any treatment.

\_\_\_\_\_  
Patient Signature Date

\_\_\_\_\_  
Patient Representative Date Relationship

\_\_\_\_\_  
Witness Date