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: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone: _____ Fax: _____

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

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

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

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