

Authorization to Release Medical Records/ Information

Patient's Name: _____

DOB: _____ Last 4 digits of Social Security Number: _____

I request and authorize Dr. Daniel Snyder of Knoxville FNA Clinic to release healthcare information of the patient named above to:

Phone number: _____ Fax number: _____

This request and authorization applies to: (please initial one)

____ 1. Healthcare information relating to treatment, condition, or specific dates listed:

____ 2. All healthcare information at this facility.

I understand that I may revoke this authorization at any time and that unless an earlier date is specified, it will automatically expire 12 months after the date affixed below. A copy of this authorization may be utilized with the same effectiveness as an original.

Print name

Person authorized to sign for patient (Print)

Patient's Signature and Date

Signature/ Relationship to patient/ Date