KNOXVILLE FNA CLINIC
DANIEL SNYDER, DO
317 Ebenezer Road
Knoxville, TN 37923
Office: 865.888.7747
Fax: 865.888.7748

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