East TN Neurology

Medical Records Release Form

Fax: 423-536-9938 Addr: 3555 Keith St NW, Suite 211 Cleveland TN 37312

PATIENT IDENTIFICATION

Patient Full Name: _____

Date of Birth: _____ Email Address: _____

Social Security Number: _____ Phone Number: _____

Address: _____

AUTHORIZATION FOR USE OR DISCLOSURE

By signing this document, I, the above-named, hereby grant permission for the use or disclosure of my health information as outlined below. I understand that this information may include records maintained by the healthcare provider concerning my physical or mental health or condition, treatment received, and billing records related to my healthcare.

Release Information To or **Obtain Records From**:

Fax: 423-536-9938 Mail: 3555 Keith St NW, Suite 211 Cleveland TN 37312

_1._____

_2. _____

_3. _____

_4. _____

_____ _____

Signature of Patient Date