Request and Authorization for Release of Medical Records

I, _____hereby voluntarily authorize
(Patient Name)
and request the disclosure of information from my health record.

Name of person or entity to release records:

_____

Patient Information:
Address: _____
Date of Birth: _____

Information Requested:

_____
_____
_____

Purpose of Release:

_____
_____
_____

This permission expires one year after the date of my signature unless another date or event is written here: _____

Please send records to
Carington Health Services
149 Durwood Road
Knoxville, TN 37922
Fax # 865.409.5739
Thank you!

_____ _____

Patient's Signature or Patient's Representative **Date**