Genesis Neuroscience Clinic

RELEASE OF MEDICAL RECORDS AUTHORIZATION

Patient's Full Name _____ **Patient's Date of Birth** _____

Address _____ **Patient's Telephone Number** _____

City, State, Zip Code _____

I request the office of Dr. _____ of

Name and Address of Practice _____

Phone Number of Practice _____ Fax Number of Practice _____

To release my most recent **office visit notes, labs, EKG and head imaging results** to:

Dr. Monica Crane // Genesis Neuroscience Clinic
1400 Dowell Spring Blvd, Suite 100
Knoxville, TN 37909

Phone Number: 865-888-9494
Fax Number: 865-444-7672

I may revoke this authorization by notifying Genesis Neuroscience Clinic in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

Signature of Individual (The person about whom the information relates) _____ Date of Signature _____ Date of Birth or Social Security Number _____

OR, if applicable

Signature of Patient's Representative _____ Date of Signature _____ Description of Authority to Act for the Individual _____

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