Channappa Chandra, M.D.
Robert C. Coddington, M.D.
Mark G. Freeman, M.D.

AUTHORIZATION TO RELEASE MEDICAL RECORDS/INFORMATION

Patient's name: ______________________________

Social Security # ______________ D.O.B. ______________

Physician to provide records: ______________________________

Person/facility to receive records: ______________________________

Address: ______________________________

City, State, Zip: ______________________________

Phone #: ______________ Fax #: ______________

Release these records:

OFFICE NOTES ________ XRAYS ________
OPERATIVE NOTES ________ LABWORK/DIAGNOSTIC TESTS ________

Expiration or revocation of authorization – 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. Use of copies – A copy of this authorization may be utilized with the same effectiveness as an original.

____

Patient Name (print) Person authorized to sign for patient (print)

____

Patient's signature Signature

____

Relationship to patient

Date: ______________________________

Memorial Medical Bldg. East – 725 Glenwood Drive, Suite 580 – Chattanooga, TN 37404
(423) 624-6584 – Fax (423) 624-6588