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