

EDMUNDS GASTROENTEROLOGY
MEDICAL RECORDS RELEASE

Name of Patient _____ Date of Birth _____

Social Security number _____

Address _____

Phone number Home _____ Cell _____

I, the undersigned, authorize the release of or request access to the information specified below from the medical record of the above-named patient.

- **PATIENT INFORMATION NEEDED FOR:**

Continuing medical care Military Social Security Disability
Legal Purposes Transfer of Care

- **INFORMATION TO BE RELEASED OR ACESSED:**

__ Complete medical chart to include all __ office notes, __ history and physical, __ procedure notes,
__ Consults, __ Lab results, __ Radiology reports, __ Pathology reports

TO: Meade Edmunds, Edmunds Gastroenterology
4713 Papermill Dr Suite 100 Knoxville, TN 37909

Phone Number: 865-851-7771
Fax Number: 865-851-7835

From: _____

Phone Number: _____

Address: _____

Fax Number: _____

- I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and is no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnosis, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.
- I understand that I may revoke this authorization in writing at any time except to extent that action has been taken in reliance upon authorization.
- The authorization will expire twelve (12) months from the date of signature unless I revoke the authorization prior to that time.

Date _____ Signature _____