KNOXVILLE FNA CLINIC
DANIEL SNYDER, DO

Authorization to Release Medical Records/Information

Patient's name: _____

Social security # (Last 4 digits): _____ DOB:_____

I request and authorize _____(referring provider)_____
to release healthcare information of the patient named above to:

Knoxville FNA Clinic
123 Fox Road, Suite 201B
Knoxville, TN 37922
Phone: (865) 888-7747 Fax: (865) 888-7748

This request and authorization applies to: (please initial one)

Initials

_____ 1. Healthcare information relating to treatment, condition, or specific dates listed: _____
_____

_____ 2. All healthcare information at this facility.

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. 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/Date Signature/Relationship to patient/Date