MEDICAL RECORDS RELEASE

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Authorization To Release Medical Records/Information

C.Rodney Susong, MD, PC - 2051 Hamill Road, Suite 301, Hixson TN 37343
Phone: (423) 870-3376 Fax: (423) 877-1387

Physician/facility to provide medical records: ____

Patient Name: ____________________________________ Date of Birth: _________________________

Phone #: ____ SSN: _______________________________

Please Release My Records To: ____

Address: ____
Street City / State / Zip

Office Number: ___________________________________ Fax #: ______________________________

I request a copy or summary of the following medical records: (please ☑ all that apply)

- ☐ Complete Medical Record
- ☐ Specific Office Visit(s)
- ☐ Pathology/Biopsy Report(s)
- ☐ Lab Report(s)
- ☐ PDT Results
- ☐ Laser/VBeam Report
- ☐ Other: ____

Please ☑ one:

- ☐ For dates of service from ___/___/___ to ___/___/___
- ☐ For all dates of service

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 from the date signed.

Patient Name (Print): ______________________________

Person Authorized to sign for patient: ______________________________

Patient Signature: ______________________________

Signature/Relationship to patient: ______________________________

Date: ______________________________

Date: ______________________________