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**PATIENT RECORDS RELEASE**

Date: \_\_\_\_\_

TO: (facility where records are held)

Name: \_\_\_\_\_

Address: \_\_\_\_\_

I hereby authorize you to release to:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medical records including the diagnosis and records of any treatment or examination rendered to me during the period from \_\_\_\_\_ to \_\_\_\_\_, or all records on file \_\_\_\_\_.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Address \_\_\_\_\_

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Chart #

FAX TO: 865 971 4887