Foot And Ankle
Specialists of Tennessee

8870 Cedar Springs Lane
Suite 104
Knoxville, TN 37923
865-686-8486

CONSENT TO RELEASE MEDICAL RECORDS

I hereby request that the following medical information be transferred:

☐ From
☐ To

☐ From
☐ To

Foot and Ankle Specialists of Tennessee
8870 Cedar Springs Lane, Suite 104
Knoxville, TN 37923
Phone / Fax: 865-686-8486

_____
_____
_____

Patient Name: _____ Date of Birth: _____

I authorize the release of my health information to/from Foot and Ankle Specialists of Tennessee PLLC including as applicable:

Information Requested:

☐ H&P and Progress Notes
☐ Operative Notes
☐ Discharge Summary
☐ Imaging and Radiologist Reports
☐ Labs and Pathology Reports
☐ All Records
☐ Records related to the specific diagnosis: _____
☐ Records for dates: _____ to _____

It is further understood that the information released is for Foot and Ankle Specialists of Tennessee PLLC only and will not be released to other entities or third parties. I further understand that correspondence, patient discharge instructions, and records from other health care providers will not be included in the routine request. This consent will expire 90 days after date of signature.

_____

Signature of Patient / Legal Representative Date

_____

Witness Signature Legal Representatives Relationship to Patient