East Tennessee
VEIN CLINIC

MEDICAL RECORDS REQUEST

To:

_____
Hospital/HealthCare Provider

_____
Street Address City State Zip

_____/_____
Phone Fax

From:

_____
Patients Name

_____
Social Security Number

_____
Date of Birth

I, _____, do hereby authorize and request the release of any and all medical record in your possession to be submitted via fax or mail to:

Andrew M. Douglass, M.D.
1344 Dowell Springs Blvd.
Knoxville, TN 37909
Fax (865)357-8346

The complete records will be necessary in order for our files to be satisfied. That includes but not limited to Progress notes, History and Physicals, treatments and prognosis, laboratory and test reports.

_____ _____
Patient Signature Date