# Medical Records Release

Patient's name _____Phone # _____

Date of birth ____/____/____

Social Security Number _____-___-_____

Address _____

_____

Please release my medical records from:

Name of provider _____Phone # _____

Provider's address _____

_____

to:

**Tennessee Regenerative Sports Medicine**
Dr. Michael Carlson
1924 Pinnacle Pointe Way #200
Knoxville, TN 37922
phone: (865) 360-1140
fax: (865) 693-1997

**PLEASE FAX TO: (865) 693-1997**

Please release all records, including but not limited to, progress notes, operative notes, laboratory test results, diagnostic tests, and x-rays.

I HEREBY AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS AS PROVIDED ABOVE.

_____Date: _____
Patient's Signature