

I do hereby authorize:

East Tennessee Vein Clinic, PC,
Andrew M. Douglass, M.D,
1344 Dowell Springs Boulevard,
Knoxville, TN 37909

the release of any and all medical record in your possession to be submitted via
fax or mail to:

Hospital/HealthCare Provider

Street Address

City

State

Zip

Phone

/

Fax

(Patients Name)

(Social Security Number)

(Date of Birth)

There will be a \$25.00 charge for the copying or faxing of your records.

Patient Signature

Date