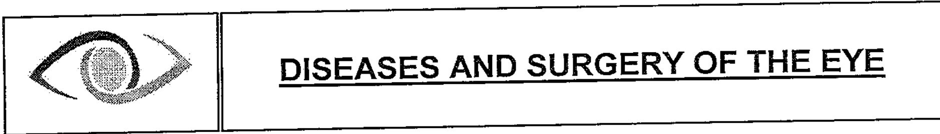

PATIENT CONSENT FOR MEDICAL RECORDS

_____ TO: MOLLY R. SEAL, M.D.
CALE HILDEBRAND, M.D.

_____ FROM: 1042 E THIRD STREET #102
CHATTANOOGA, TN 37403
PHONE (423) 265-1651
FAX (423) 756-0050

****

DOCTOR / FACILITY/ PATIENT INFORMATION:

_____ TO: NAME: ______________________________

ADDRESS: ______________________________

_____ FROM: ______________________________

PHONE: (_____) ______________________________

FAX: (_____) ______________________________

I HEREBY AUTHORIZE RELEASE OF MY MEDICAL RECORDS AS REQUESTED:

_____ FULL RECORDS _____ VERBAL CONSULTATION

PATIENT NAME: ______________________________

DATE OF BIRTH: ____________________ SSN#: ________________

PATIENT SIGNATURE/
LEGAL GUARDIAN: ______________________________

DATE SIGNED: ____________________

DATE REQUEST SENT: ____________________

The information in this request is confidential and privileged. If you receive this request in error, please contact our office at the above numbers. Thank you.