TENNESSEE FERTILITY Institute

Authorization for Release of Information to Donna R. Session, MD
Phone# 615-721-6250 Fax# 615-721-6251

Date_____

Patient Information:

_____ Name
_____ Date of Birth
_____ Address
_____ City, State, Zip code
_____ Phone (Including Area Code)

I request the following medical records:

____ Entire Patient Record
____ Office Notes/Physician Dictation
____ Surgery Op/Path Reports
____ X-Ray/Imaging Films and/or Reports
____ Lab Results
____ Other

Released from:

_____ MD and/or Clinic where treated
_____ Address
_____ City, State and Zip Code
_____ Phone (Including Area Code)
_____ Fax (if available)

To Donna Session, MD for the specific date(s) of service: _____

Needed by _____

Patient Signature: _____