

**PERMISSION TO RELEASE MEDICAL RECORDS**

**DATE:** \_\_\_\_\_

**CLARKSVILLE ORTHOPEDICS, PLC  
DUNCAN MCKELLAR, M.D.  
311 LANDRUM PLACE, SUITE 600  
CLARKSVILLE, TN 37043**

**TEL: 931-553-5495      FAX: 931-553-5497**

**I HEREBY AUTHORIZE YOU TO RELEASE MY RECORDS TO:**

\_\_\_\_\_  
**PHYSICIAN'S NAME OR HOSPITAL NAME**

**ADDRESS:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**TEL:** \_\_\_\_\_ **FAX:** \_\_\_\_\_

**PATIENT'S NAME:** \_\_\_\_\_

**SOCIAL SECURITY NUMBER:** \_\_\_\_\_

**DATE OF BIRTH:** \_\_\_\_\_

**PATIENT'S SIGNATURE:** \_\_\_\_\_