

The Lett Center

1409 Baddour Pkwy
Lebanon, Tn 37087

Phone: (615) 443-0901

Fax: (615) 443-0310

MEDICAL RECORDS RELEASE AUTHORIZATION

I, _____ do authorize release of my
medical records and

Patient Name

information to the following physician for the purpose of further medical
treatment.

**Dr. E. Dwayne Lett
1409 Baddour Parkway
Lebanon, TN 37087**

From:

Physician:

Address:

City, State, Zip:

(City or town is required)

Phone: _____

Fax:

(Phone OR Fax is required)

Records requested:

I certify that this request has been made voluntarily and that the information given above
is accurate to the best of my knowledge. I understand that I may revoke this
Authorization at any time, except to the extent that action has already been taken to
comply with it. A copy or facsimile of this Authorization with my signature may be used
with the same effectiveness as an original.

Printed Name: _____ DOB:

SSN: _____ Phone: _____

Address: _____ City, State, Zip: _____

Signature: _____ Date: _____

Witness Signature: _____ Date: _____

****This authorization is effective for the duration of the illness/ injury for which it was obtained.**