



3069 S. Broad St. #7d - Chattanooga, TN 37408 - 423.517.7070 - www.foxholeslc.com

### Authorization for Release of Information

I, \_\_\_\_\_, authorize Greg Seymour to:  
(patient or guardian)

\_\_\_\_\_ provide information as indicated: \_\_\_\_\_

\_\_\_\_\_ exchange information as indicated: \_\_\_\_\_

\_\_\_\_\_ receive information as indicated: \_\_\_\_\_

regarding \_\_\_\_\_ treatment and status to/with/from:  
(patient's name) (circle)

Name: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

I understand that I may revoke this consent at any time by written request to the authorized person. The revocation is effective on the date the request is received and placed in the medical record.

Patient's DOB \_\_\_/\_\_\_/\_\_\_ and SS#: \_\_\_\_\_

\_\_\_\_\_  
Signature Date  
(Patient or Guardian)

\_\_\_\_\_  
Witness Date