

**MARVEL CLINIC  
&  
CENTER FOR DAY SURGERY**  
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Ear, Nose, and Throat  
Allergy  
Facial Cosmetic Surgery

**MEDICAL RECORDS RELEASE AUTHORIZATION**

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

TO: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ I hereby authorize, direct, and order you to release all my medical records and any and all information concerning my medical examination, diagnosis, and treatment rendered to me.

\_\_\_\_\_ I hereby authorize, direct, and order you to release only the specific medical records indicated below.

\_\_\_\_\_

Please forward these records to: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature: \_\_\_\_\_

Witness: \_\_\_\_\_

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

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_