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AUTHORIZATION TO RELEASE MEDICAL INFORMATION
(All sections must be completed)

Patient Name: _____ Date of Birth: ___ / ___ / ___

Address: _____

City: _____ State/Zip: _____ Phone#: _____

I hereby authorize Tennessee Retina, P.C. and its physicians and employees to release or disclose all medical records to the recipient named below.

I hereby authorize the release of medical records TO or FROM (please circle which one):

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Purpose of release or disclosure:

____ Information needed by another medical provider

____ Information for patient's personal records

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____ Other: _____

Signature of Patient or Authorized Representative

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Relationship to Patient _____