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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):**

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

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

State/Zip: \_\_\_\_\_ Telephone : \_\_\_\_\_ Fax: \_\_\_\_\_

**Purpose of release or disclosure:**

\_\_\_\_\_ Information needed by another medical provider

\_\_\_\_\_ Information for patient's personal records  
(TNR staff to indicate what was released & initial)

\_\_\_\_\_ Other: \_\_\_\_\_

**Signature of Patient or Authorized Representative**

\_\_\_\_\_ **Date Signed** \_\_\_\_\_

**Relationship to Patient** \_\_\_\_\_