EVERTON L. ARRINDELL, M.D.
CARL C. AWH, M.D.
BRANDON G. BUSBEE, M.D.
KENNETH P. MOFFAT, M.D.
ERIC W. SCHNEIDER, M.D.
FRANCO M. RECCHIA, M.D.
DAVID A. REICHSTEIN, M.D.
PETER L. SONKIN, M.D.
R. TRENT WALLACE, M.D.

TENNESSEE RETINA

CENTENNIAL PROFESSIONAL PLAZA
345 23RD AVENUE NORTH, SUITE 350
NASHVILLE, TN 37203
(615) 983-6000 PHONE
(615) 320-1213 FAX
WWW.TNRETINA.COM

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(All sections must be completed)

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

Patient Name:_____Date of Birth:____/____/____

Address:_____

City:_____State/Zip:_____Phone #:_____

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

A processing fee of $20 for five (5) pages or less in length plus fifty cents ($0.50) for each page copied after the first five (5) pages plus the actual cost of mailing applies to records provided for patient's personal use.