

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



CENTENNIAL PROFESSIONAL PLAZA
345 23RD AVENUE NORTH, SUITE 350
NASHVILLE, TN 37203
(615) 983-6000 PHONE
(615) 983-6010 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