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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.