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# AUTHORIZATION TO RELEASE MEDICAL INFORMATION
## (All sections must be completed in black ink only)

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** _____