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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 <u>TO</u> or <u>FROM</u> (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 _____