Everton L. Arrindell, M.D.
Carl C. Awh, M.D., FASRS
Brandon G. Busbee, M.D.
Bernard Dib, M.D.
Hesham K. Gabr, M.D., M.Sc.
Jay P. Glover, M.D.
Sarah M. Kamal, M.D.
Brigid K. Marshall, M.D.
Franco M. Recchia, M.D.

Tennessee Retina

David A. Reichstein, M.D., FASRS
Eric W. Schneider, M.D., FASRS
Marcus J. Solomon, M.D.
Akshay S. Thomas, M.D., M.S., FASRS
R. Trent Wallace, M.D.
Lauren M. Wright, M.D.
Mitchell T. Allphin, M.D. *fellow*
Ogul E. Uner, M.D. *fellow*

(615) 510-8237 records Fax
medicalrecords@tnretina.com

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

All sections must be completed in **BLACK INK**

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 receive all medical records **TO** or **FROM**

(please circle which one)

Name: _____

Address: _____ City: _____

State/Zip: _____ Phone#: _____ Fax: _____

Email: _____

Purpose of release or disclosure

☐ Information needed by another medical provider

☐ Information for patient's personal records

☐ Other: _____

Signature _____ **Date** _____

(patient or authorized representative)

Relationship to Patient: _____

Office Use Only: ☐ Email ☐ Fax ☐ Mail Initials: _____

Additional Notes: