LODEN VISION CENTERS

Authorization for Release of Medical Records

(PLEASE PRINT)

DATE: _____

TO: _____

_____

_____

I hereby authorize and request that all information concerning the medical history, examinations, treatments, hospitalizations and/or surgery for the following patient(s) be released to:

LODEN VISION CENTERS
520 Rivergate Pkwy
Goodlettsville, TN 37072
Phone: (615) 859-3937 / FAX: (615) 859-3919

Patient's Name: _____ Date of Birth: _____

Signed: _____ Date: _____
(*Parent, Guardian or Designated Healthcare Representative, if applicable*)

Relationship to Patient: _____

Patient Address: _____
(Street Address)

_____
(City) (State) (Zip)

~ This release shall be effective for sixty (60) days and is subject to written revocation, except to the extent action has been taken in reliance on the authorization. ~

For Loden Vision Center's use only . . .

Action Taken: _____

Date: _____ By: _____