LODEN iVISION CENTERS.

The undersigned hereby authorizes the release of medical records as follows:

Patient Name _____
First *Middle* *Last*

_____
Address *City / State / Zip*

_____
Patient's Date of Birth *Phone Number (please list area code)*

I authorize:

Loden Vision Centers
520 Rivergate Parkway
Goodlettsville, TN 37075

Loden Vision Centers of Paris
1024 Kelley Drive
Paris, TN 38242

To release information regarding my medical care and treatment to:

_____

_____

_____

Information to be released:

_____ All eye care treatment records

_____ "K" Readings

_____ Operative Records

_____ A-Scans

Special Note: I understand that all information disclosed may contain matter that is protected by federal and state laws, including information which may relate to ALCOHOL AND DRUG ABUSE, PSYCHIATRIC DISORDERS AND TREATMENT, AIDS and HIV TESTING and/or OTHER SEXUALLY TRANSMITTED DISEASES. I specifically consent to release and disclosure of this information, including transmission of my medical records via a facsimile machine.

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

Relationship to Patient: _____