Authorization for Release of Medical Records to Loden Vision Centers

(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 ***(please circle the desired location):***

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

Loden Vision Centers of Paris
1024 Kelley Drive
Paris, TN 38242
Phone: (731) 642-5003 / FAX: (731) 642-8756

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: ________________________