CORNEA &
CATARACT
CONSULTANTS
OF NASHVILLE, P.L.L.C.

Eye M.D.s

Surgery and Diseases of the Eye

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Authorization To Release Medical Records/Information

Physician to provide records: ______________________________
Physician's Phone Number: ______________________________
Patient's Name: ______________________ Date of Birth: ______________
Social Security Number: ______________________________

Person/Facility to receive records: ______________________________
Address: ______________________________
City: ______________ State: ________ Zip: ______________
Phone Number: ______________________________

1. Release all health care information: ______________________________
2. Health care information relating to the following treatment, condition, or dates: ______________________________
3. Other: ______________________________

If you do not want certain portions of your medical records released, please read this section carefully and initial spaces for information you do not want released. Otherwise, your records will be released as specified as above.

I authorize the health care provider to release the information specified to the organization, agency, or individual named on this request, with the Exception of:

Substance abuse, if any: ______________ AIDS/HIV, if any: ______________
Psychological or psychiatric conditions, if any: ______________________________
Other (please specify): ______________________________

Expiration or revocation of authorization—I understand that I may revoke this authorization at any time and unless an earlier date is specified, it will automatically expire 12 months after the date affixed below. Use of copies—A copy of this authorization may be utilized with the same effectiveness as an original.

Patient Signature: ______________________________ Date: ______________
Person authorized to sign for patient: ______________________________
Relationship to patient: ______________________________ Date: ______________