MT JULIET
EYE CLINIC

MEDICAL RECORDS REQUEST

Date: _____

TO: _____
Name of Doctor/Facility

_____
Address

_____ _____
Phone Fax

I, _____, hereby request that my medical records covering the period _____ to _____ be released to:

Mt Juliet Eye Clinic
300 Pleasant Grove Rd
Building 600
Mt Juliet, TN 37122

Tele: (615) 773-5773
Fax: (615) 832-4321

_____
Print Name

_____
Address

_____
Date of Birth

_____
Signature