MT JULIET EYE CLINIC

300 Pleasant Grove Rd.
Building 600
Mt Juliet, TN 37122
Tele: (615) 773-5773
Fax: (615) 832-4321

Permission to Release Medical Records

Date: _____

I, _____, grant permission to *Mt Juliet Eye Clinic* to release my personal medical records to _____.

The medical findings and treatment disclosed should cover the period from _____ to _____. In signing this request, I hereby release my Practitioner from any laws governing the disclosure of confidential or privileged information.

_____ _____
Signature of Patient or Legal Guardian Date of Birth

_____
Printed Name

Name of Facility to Send Records To:

_____
Name

_____
Address

_____ _____
Phone Fax