

Authorization to Obtain Medical Information

I, _____ hereby authorize
_____ and its physicians,
employees and agents to release or disclose my individual health information to:

The Regional Eye Center

**135 W Ravine Road, Suite 2C
Kingsport, TN 37660
Phone: 423-246-7372
Fax: 423-246-5038**

Purpose of disclosure: To assist in the provision of services, care, and treatment of the individual
 At the request of the individual Other: _____

Information requested to be disclosed is:

_____ **All medical records**

_____ **Health care information relating to the following treatment condition, or dates of treatment:**

_____ **Specific records to be released (Labs, imaging reports, other):**

**** This authorization expires one (1) year from the date executed unless otherwise specified:**
Expiration Date _____

Patient Signature or Authorized Representative

Patient's Date of Birth

Date Signed

If Authorized Representative, Relationship to Patient _____