# Essential Eyes

Dr. Stephanie Price, OD

1940 Shady Brook St. Suite E Columbia, TN 38401

Phone: 931-380-2660 / Fax: 931-380-1004


## Medical Release Form:

Patient's Name:_____ Date of Birth:_____

Address:_____City:_____State:_____Zip:_____

Phone: _____

I hereby authorize the release of my medical records TO: ☐ Myself

☐ Essential Eyes/ Dr. Stephanie Price, OD Fax: 931-380-1004

1940 Shady Brook St. Suite E Phone: 931-380-2660

Columbia, TN 38401

FROM:

☐ Office/Physician:_____ Fax:_____

Address: _____ Phone:_____

City: _____State:_____Zip:_____

**Note:** Please include: ☐ Last glasses/contact Rx

☐ Last exam including testing and clinical notes ☐ Last 3 exams including testing and clinical notes

☐ Entire record including consult letters, referral letters, clinical testing (VF, Photos, OCT, etc.)

*I understand that I will be charged the State of TN Records Access Act Fees, plus postage to copy these records. I also understand this release is effective for six months from today and I may revoke my consent at any time by written consent. (The revocation must be legible and include the name, date of birth, and date of revocation.)

*I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or eligibility of benefits.

*Unless otherwise revoked in writing, this authorization will expire ONE YEAR from the signature date below or on the following date, event, or condition:

I,_____, certify that I am the patient or legal guardian with the authority to authorize disclosure of this individual's protected health information.

_____ _____ _____

*Signature of patient/legal guardian* *Relation to patient/legal authority* *Date*