



AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION (Please Print):

Name: _____

Date of Birth: _____

Social Security Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____

RELEASE MY MEDICAL RECORDS FROM:

Name: _____

Tel: _____

Fax: _____

TO:

LOTUS VISION
3400-A Old Milton Parkway – Suite 520
Alpharetta, GA 30005

Phone: (678) 762-1700

Please release a copy of all my medical records, including but not limited to, progress notes, operative notes, laboratory results and diagnostic tests.

BY MY SIGNATURE BELOW, I AUTHORIZE RELEASE OF MY MEDICAL RECORDS.

Patient: _____ Date: _____