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: ______________________________________

PLEASE FAX ALL RECORDS TO 866-435-3634

LOTUS VISION
3400-A Old Milton Parkway – Suite 520
Alpharetta, GA 30005
Phone: (678) 762-1700
Fax: (866) 435-3634

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 Signature: ______________________________________ Date: __________________________