LOTUS VISION

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION (Please Print):

Name: ______________________________________

Date of Birth: ________________________________

Address: ______________________________________

City: _____________ State: ______ Zip Code: ________

Phone: _______________________________________

RELEASE MY MEDICAL RECORDS TO/FROM:

Name: __________________________________

Tel: ____________________________________

Fax: ____________________________________

LOTUS VISION
3400-A Old Milton Parkway – Suite 520
Alpharetta, GA 30005
Phone: (678) 762-1700
Fax: 1-(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: ________________________