# Riverview Eye Care

1535 Northfield Blvd, Ste 12, Murfreesboro, TN 37129
Phone: (615) 703-3884 | Fax: (615) 807-3923 | Email: info@rectn.com

## Medical Records Release Form

| | |
|---|---|
| Patient Name: | Date of Birth: |
| Address: | Phone Number: |
| City, State, Zip: | Date: |

**Authorization**

I authorize **Riverview Eye Care** to: ☐ Release records to ☐ Obtain records from:

| |
|---|
| Provider / Facility Name: |

**Records Requested (check all that apply)**

☐ Entire medical record
☐ Last examination / visit notes
☐ Glasses / contact lens prescription
☐ Other: _____

**Reason for Request (check one)**

☐ Continuing care ☐ Insurance / legal ☐ Personal copy ☐ Other: _____

***I understand that:***

- I may revoke this authorization at any time in writing.
- My treatment is not conditioned on signing this form.
- This authorization expires one year from the date signed unless otherwise specified.

| | |
|---|---|
| Signature of Patient or Authorized Representative | Date |
| Relationship to Patient (if not the patient) | |

**Office Use Only**

MR#: _____ Date Processed: _____ Staff: _____