THE REEVES EYE INSTITUTE
YOUR VISION, OUR MISSION

MEDICAL RECORDS RELEASE

PATIENT NAME	DATE OF BIRTH	SOCIAL SECURITY #
ADDRESS		
CITY	STATE	ZIP

I HEREBY AUTHORIZE

_____
FACILITY NAME

TO RELEASE **ALL** THE MEDICAL RECORDS OF _____
PATIENT NAME

TO: **THE REEVES EYE INSTITUTE**
2685 BOONES CREEK ROAD
JOHNSON CITY, TN 37615

PHONE: (423)722-1311
FAX: (423)722-4950

PATIENT SIGNATURE/PARENT/CONSERVATOR/GUARDIAN	RELATIONSHIP TO PATIENT
WITNESS SIGNATURE	DATE