Mt. Juliet Family Vision

Michael K. Davis, O.D.
Peter M. Davis, O.D.
Kevin M. Davis, O.D.
1005 Charlie Daniels Pkwy
Mt. Juliet, TN 37122
Phone: (615) 758-2501
Fax: (615) 758-2524

RECORD RELEASE REQUEST

TO:____

ADDRESS:______________________________________

PHONE:____________________**FAX:**_______________

I, ___________________________, hereby authorize you to release to Mt. Juliet Family Vision Center any information including the diagnosis and records of any treatment of examination rendered to me during the period from __________________ to ________________________.

Thank you for your immediate and prompt attention to this request.

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Patient's Printed Name **Date** **Patient's Signature**

_________________ ______________________________________

DOB **Appointment Date**