2230 Roswell Road
Suite 100
Marietta GA 30062-2945
T (678) 903-2579 F (678) 903-2583

RECORDS RELEASE FORM

_______ / _______ / _______

TO: Doctor: ______________________________

Address: ______________________________

____

Phone: (_____) ______ - __________

Fax: (_____) ______ - __________

I ____ grant permission to ___________________________________
(Patient or Guardian) (Doctor Currently Holding Records)

to disclose to Marietta Vision Professionals, complete information concerning the medical findings and treatment of

___________________________. The requested records should cover all information from _____ / _____ / _____ to
(Patient)

present. I release the doctor holding the records from any laws related to disclosure of confidential or privileged information.

____
Signature of Patient or Guardian

www.mymariettavision.com