



Lentz Pediatrics

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Jackson, TN 38305
Phone 731-664-9040
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Authorization to Release Medical Information

Patient's Name: _____

Patients' Date of birth: _____

Patient's Address: _____

Patient's Social Security Number: _____

The above identified patient is requesting the following information to be made available to:

Name of Person to receive the information: Lentz Pediatrics

Address receiving information: _____

Phone Number of Person receiving information: _____

Name of Person/Organization releasing the information: _____

Address releasing information: _____

Date of Service From: _____

Please list any records you **do not** wish to release: _____

Signature of Patient: _____

Date: _____

If not signed by the patient:

Signature of Parent/Guardian: _____

Relationship to patient: _____