Dr. Robert R. Szeliga
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REQUEST FOR MEDICAL RECORDS

Physician/Organization Providing Medical Records:_____
Address:_____
_____
_____
Phone:_____
Fax:_____

Please send records to:
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5328 Main Street
Spring Hill, TN 37174
Phone: 931-489-1950
Fax: 931-489-1953

Patient Information
Patient Name:_____
Date of Birth:_____
Address:_____
_____
Phone #:_____

I give my permission to release my medical records to Spring Hill Eyecare, PLLC.
Patient's Signature:_____
Parent/Guardian Signature:_____
Date:_____