Dr. Michael N. Kleamenakis
4114 Marigny Street
New Orleans, LA 70122
P: 504-288-2333
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Authorization to Obtain and Release Medical Records

Date: _____

I, _____, hereby authorize the release of
Legal Guardian/Parent or Patient's Name (Print)

medical records for _____, D.O.B.: ____ /____ /_____,
Patient's Name (Print)

SSN: _____-____-_____, to/from Gentilly Vision Source.

Thank you,

_____ ____/____/_____

Legal Guardian/Parent or Patient's Name (Print) Date of Birth

_____ _____

Legal Guardian/Parent or Patient's Signature Date

Requesting: Exam notes CL RX Glasses RX

Other:_____

Send Records: ATTN: Front Desk 504-288-2227_____
Contact Representative / Fax Number

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