

MEDICAL RECORDS RELEASE

NAME OF PATIENT

BIRTHDATE

Authorizes:

to Release Records to:

Name of Physician or Facility

Street Address

City State Zip Code

Information to be released:

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Clinical Records | <input type="checkbox"/> Eye Records | <input type="checkbox"/> Visual Fields | <input type="checkbox"/> Allergy Records |
| <input type="checkbox"/> Office Notes | <input type="checkbox"/> X-ray Reports/ Films | <input type="checkbox"/> Lab Reports | <input type="checkbox"/> Electrocardiogram |
| <input type="checkbox"/> Photographs | <input type="checkbox"/> Other | | |

List other records to be included when releasing for the purpose of continuing medical care (Include Dates):

I authorize release of my medical records in accordance with the specifications listed above. I understand written notice is necessary to cancel this request.

Signature of Patient _____ **Date** _____

If signed by person other than patient, state relation:

Authorized Signature _____ **Relationship** _____