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Laser Vision Correction

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Medical Record Release Request (Please print clearly)

Step 1: Personal information

Name: _____

Date of Birth _____

SSN _____

Step 2: Who has the records now?

I hereby authorize:

Dr. _____; From the office of: _____

Phone # _____ Fax# _____

Address _____ City _____

State _____ Zip _____

Step 3: What records would you like released?

To release the following information:

Contact lens Rx

Spectacle Rx

All records

Other: _____

Step 4: To whom do you wish to release your records?

To: Dr. _____; From the office of: _____

Phone # _____ Fax # _____

Address _____ City _____

State _____ Zip _____

I understand that without this authorization, the provider would not be permitted to disclose this information, as indicated by law. I further understand that this information will become part of my case history.

Thank you,

Patient or Legal Guardian Signature

Date _____