eyecarecenter

A MEMBER OF Vision Source

Medical Release Form

Patient's name: ____

Date of birth: _________/_________/_________

Social Security Number: ___________-________-____________

Telephone number: (_________) _________-____________

Please release my medical records To / From:

Name of Doctor/Facility - ____

Doctor/ Facility's address - ____

Doctor/ Facility's Telephone - (_________) _________-____________

Doctor/ Facility's Fax - (_________) _________-____________

TO / FROM:

Eye Care Center

903 William D Fitch Pkwy

College Station, TX 77845

T(979)779-9000 F(979)690-1510

Dr. Belinda Dobson, O.D.

Dr. Abby Zike, O.D.

Dr. Isis Kaldas, O.D.

Please release all records, including but not limited to, progress notes, operative notes, laboratory test results, diagnostic tests, glasses prescriptions, and contact prescriptions.

I HEREBY AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS AS PROVIDED ABOVE.

Guardian/Patient's Signature: ____ Date: ________________