

Medical Records Release

PATIENT: _____

DOB: _____ AGE: _____

CURRENT ADDRESS: _____

CURRENT PHONE: _____

PCP: _____

DATE OF REQUEST: _____

I hereby authorize the release of my complete medical records in the possession of Tri-County Eye Physicians & Surgeons, PC concerning my illness and/or treatment to:

Doctor

Address

Practice Name

City, State, Zip

Patient Signature: _____ Date: _____

***If you are moving, please provide your new address and phone number below.*

Address

City, State, Zip

Phone

Patient's Reason for Requesting Records:
