TOTAL EYECARE

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Release Records Request Form

Receive the following information from:

Facility:_____
Provider:_____
Phone #: _____
Fax #: _____

Release the following information to:

Facility:_____
Provider:_____
Phone #: _____
Fax #: _____

Patient Name: _____
Date of Birth: _____
Parent/Guardian: _____
Street Address: _____
City, State, Zip: _____

Please Disclose The Following Information:

□ Last Visit
□ One Year
□ Two Years
□ Complete Medical Record
□ Other (please specify) _____

Patient Name Printed: _____

Patient Signature: _____

Parent/Guardian Name Printed: _____

Parent/Guardian Signature: _____Date: _____