VisionCare
ASSOCIATES

MEDICAL RECORDS RELEASE

Ph: 517.337.8182 • Fx: 517.332.0038

_____ _____
(Name of Patient) (Birthdate)

_____ _____
(Street Address) (City/State/Zip)

Authorizes:

_____
(Name of Physician or Health Care Facility)

_____
(Street Address)

_____
(City/State/Zip)

Release of Records to:

_____
(Name of Physician or Health Care Facility)

_____
(Street Address)

_____
(City/State/Zip)

Please release the following:

[ ] All clinical records,starting _____
(date)

[ ] Most recent examination

[ ] Other (ex: visual fields, glaucoma screenings, etc.)

I grant permission to the above mentioned practice to release my patient records to _____ . The medical findings and treatment disclosed should cover the period of time requested. In initiating this request, I hereby release my practitioner from any laws governing the disclosure of confidential or privileged information.

_____ _____
(Patient Signature) (Date)

Number of pages including cover sheet _____

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310 W Lake Lansing Rd • East Lansing, MI 48823 | visioncare@visioncarepc.com | www.visioncarepc.com