Medical Records Release Form

To: _____

_____

_____

Fax: _____

Sergeant Bluff EyeCare
105 Gaul Dr.
Sergeant Bluff, IA 51054
Phone: 712-943-9400
Fax: 712-943-9403

Patient Name: _____

DOB: _____ /_____ /_____

□ This patient has come to our office for their eye care and vision needs. At the patient's request, please forward all of their medical records, including a complete contact lens prescription (if relevant) to our office.

□ This patient is transferring their care to your office for their eye care and vision needs. At the patient's request, their medical records are being transferred to your office.

□ Note: We are specifically requesting the following information regarding this patient:
_____
_____
_____

Please forward the requested information at your earliest convenience.

I hereby grant the above named person(s)/medical facility permission to exchange information from my records.

_____ _____

Signature Date