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MEDICAL RECORD RELEASE FORM

Patient's Name_____Date of birth_____

I authorized to have my medical record release to/from:

☐ for all my medical record to be released to this clinic below OR

☐ for EyeRis Vision to release my medical records to this clinic below:

Dr. _____Clinic _____

Phone #_____Fax #_____

☐ to have this person, named below, to have access to my medical records

Name_____Relationship_____

Phone #_____Fax #_____

Additional notes:_____

If guardian, Print Name:_____Date_____

Patient/Guardian's Authorization Signature: _____

Staff Name: _____Requested date_____