Mission Eye Clinic

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MEDICAL RECORDS RELEASE FORM

Date: _____ PHN:_____

Patient Name:_____ Date of Birth:_____

Address:_____

Phone:_____ E-Mail:_____

SEND RECORD OUT	I request and authorize Mission Eye Clinic to release information to: Provider or Organization:_____ Address:_____ Phone:_____ FAX:_____ E-Mail:_____
RECEIVED RECORD	I request and authorize the provider/clinic indicated below to release information to Mission Eye Clinic: Date Range of Records:_____ Provider or Organization:_____ Address:_____ Phone:_____ FAX:_____ E-Mail:_____

Patient Signature:_____ Date:_____