Medical Records Release Form

To: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Eye Consultants of Colorado

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 10791 Kitty Drive; Suite B

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Conifer, CO 8033

Fax: 303.816.7218

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

□This patient has come to our office for their eye care and vision needs. At the patients 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.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Signed Please print Last name, first name Date