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