MEDICAL RECORDS RELEASE

To _____ **Fax Number** _____

_____

_____

I hereby authorize and request that a copy of the medical records concerning my illness and/or treatment during the period from:

_____ to _____ ❑ Present ❑ All records

be provided according to the instructions indicated below. In addition, please provide copies of the following, if any:

- Fluorescein Angiographs
- Retinal or other photographs
- Visual Field tests

Comments:_____

_____

_____

❑ Please send copies of my medical records to the individual and address listed above.

or

❑ Please send copies of my medical records to San Luis Obispo Eye Associates: Mail or Fax to (circle location) San Luis Obispo 805.781.9013 or Templeton 805.434.5973

Patient Name _____ **DOB**_____

Signature _____ **Date**_____

_____
Print name if parent or legal guardian

Date faxed _____

Staff initals _____