



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 initials _____

