SAN LUIS OBISPO EYE ASSOCIATES
A Medical Group, Inc.

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 angiograms
- 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 at the address indicated at the bottom of this letterhead.

Patient Name _____ **DOB** _____

Signature _____ **Date**_____

_____
Print name if parent or legal guardian

faxed_____

by_____

012419

689 Tank Farm Road, Suite 100
San Luis Obispo, CA 93401
(805) 781-3937 • fax (805) 781-9013

Larry B. Baldwin, MD
W. James Gealy, Jr., MD
Sharon M. Theodore, MD
Frank M. Basich, MD
Rena A. Stathacopoulos, MD
Joseph R. Horne, OD

www.sloeyeMD.com

234 Heather Court, Suite 102
Templeton CA 93465
(805) 434-5970 • fax (805) 434-5973