MEDICAL RECORDS RELEASE FORM

Date:_____

Doctor Name:_____

Fax Number: _____

I hearby authorize you to release my records to: Dr. Smith/Dr. Deemer at

Westbrook Vision Center PLC
8877 W. Union Hills Drive Ste 460
Peoria, AZ 85382
PH 623.256.0400
FAX 623.376.6800

Any information, including diagnosis and records, of any treatment or examination rendered to me during the period from _____ to _____.

Special instructions:

_____

_____

_____

_____

PATIENT:

Printed_____DOB_____

Signature_____