

Release of Records

Date: _____

Patient Name: _____

Date of Birth: _____

SS#: _____

Phone Number: _____

I hereby authorize the release of my medical and/or vision records to:

Advanced Eye Care
Dr. Denise Harvey/Dr. Jessica Downs
Bowling Green 573 324 3131
Winfield 636 668 6171
Troy 636 528 4144

From Dr. _____

Their Phone and Fax: _____

Sincerely,

Signature Line

X _____