

Healing The Eye Wellness
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PATIENT RECORD RELEASE FORM
Please Print and fill out.

PATIENT INFORMATION:

Name: _____

Street: _____

City: _____ State: _____ Zip Code: _____

Daytime Phone: _____ Evening Phone: _____

HOLDER OF RECORDS:

Doctor's Name: _____

Address: _____

Telephone: _____ Fax # _____

**I AUTHORIZED THE RELEASE OF MY MEDICAL RECORDS TO THE ABOVE
CHECKED ADDRESS**

_____ Visual Fields _____ Results of Other test

_____ Fundus Photographs _____ Other _____

_____ Flourescine Angiogram

Patient Signature _____ Date _____