Records Release Form

Regarding:

Patient Name: DOB:

Information Requested From:

Name:

Address:

City: State: Zip:

Phone: Fax:

Send Information To:

Visual Expressions Optometry
3580 Blackhawk Plaza Circle, Danville, CA 94506
Phone: 925.648.9393 | Fax: 925.648.9394
Email: info@visualexpressionsoptometry.com

I, _____ (*Name*) , herby grant permission for you to release confidential health information about me, by releasing a copy of my medical record, or a summary or narrative of my protected health information, to the physician/person/facility/entity.

Printed Name: _____ Date: _____

Signature: _____