

Medical Records Request

Provider/Entity: _____

Address: _____

City / State / Zip: _____

Secure email: _____

Fax: _____

Information Requested:

I _____ (patient full name) authorize the above-named provider/entity to release the following designated medical information.

Copy of complete medical records including results of diagnostic testing

Copy of contact lens prescription

Copy of spectacle lens prescription

Other information _____

Release Authorized to:

A New Concept Optical & Eyecare

2528 Dell Range Blvd

Cheyenne, WY, 82009

Fax: _____

Secure email: _____

I HAVE READ AND UNDERSTAND THIS FORM. I VOLUNTARILY AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM. IF I AM SIGNING FOR A MINOR, MY SIGNATURE ATTESTS THAT I HAVE LEGAL AUTHORITY OVER MEDICAL DECISIONS FOR THE DESIGNATED MINOR.

Print Name DOB (unless signing for minor)

Date ____ / ____ / ____

Patient or legally authorized individual signature

Printed name if signed on behalf of the patient Designate parent or guardian DOB of minor (if signing for minor)