Medical Records Release Form

Patient Name _____ Date Of Birth _____/_____/_____

Address _____City _____State _____Zip_____

Phone _____ Email _____

I, _____ authorize the doctor and staff at Apex Eye Care to release my information, including records rendered to me, diagnosis, treatment, tests and claims information. This information can be released to:

[ ] myself

[ ] spouse _____

[ ] Child(ren) _____

[ ] Doctor's office _____

Address _____

Phone _____ Fax _____

The release of information will remain in effect until terminated by me in writing

_____ _____/_____/_____

Patient (Guardian) signature Date