WALLINGFORD
EYE CARE CENTER

Record Release

Please fill out this form in its entirety to authorize the release of medical records for:

Patient Name: _____ DOB: ____/____/____

REQUESTING FROM:

Doctor or Practice Name: _____

Address: _____

_____

Phone: _____ Fax: _____

RELEASING TO:

☐ Patient

☐ Doctor or Practice

Name: _____

Address: _____

_____

Phone: _____ Fax: _____

_____ ____/____/____

Patient or Guardian Signature Today's Date

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