San Carlos
EYE CARE

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Patient Name ____

Date of Birth ____________________ Phone:________________________

I hereby authorize ____

to release a copy of my health information to:

☐ San Carlos Eye Care

☐ ______________________________ Fax: ___________________

Description of Information to be released: (check all that apply)

☐ Entire medical record

☐ Immunization record
☐ Laboratory reports
☐ Radiology/Imaging reports
☐ Radiology films
☐ Other____

☐ Most recent history and physical
☐ Consultations
☐ Progress notes

Time period these records cover

☐ All
☐ From _______________ To _______________

____ ___________________
Signature of Patient or Patient's Representative Date

____
Printed Name of Patient or Patient's Representative