Eye Physicians of the East Bay

Medical Corporation

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RELEASE OF MEDICAL RECORDS/INFORMATION

I hereby authorize Eye Physicians Of The East Bay to release copies of my medical records or requested medical information as specified below.

Request release of the the following medical information:

( ) Full medical record
( ) Specified medical record information as follows: _____

Release to:

Practice/Facility Name: _____

Provider Name: _____

Address: _____

City/State/Zip: _____

Phone: _____

Fax: _____

I understand I have the right to receive a copy of this authorization.

Patient Name: _____ **D.O.B :** _____

Patient Address : _____

Signed: _____ **Dated:** _____

If not signed by the patient, please indicate relationship:

( ) Parent or guardian of minor patient (if minor could not have consented to the care)
( ) Guardian or convervator of an incompetent patient

If required, Treating Physician:

Signed: _____ Dated: _____