Medical Records Release Form

This form is posted on our website www.kidseyecare.net

Caring For the Vision of Our Future

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Release of Medical Records For the Following Patient (s):

Name: ______________________________ Date of Birth: ____________

Name: ______________________________ Date of Birth: ____________

Name: ______________________________ Date of Birth: ____________

Letter authorizes Pediatric Ophthalmology Associates to provide a copy of my /my child's medical records:

☐ Record of Care from ______________________ to ______________________
(date) (date)

☐ Child's Complete Medical Record

I hereby request that my/my child's medical records be released to:

Name: ____

Fax# ____

Phone #: ____

Address: ____

City, State, Zip: ____

Purpose for release of records:

☐ Referring Specialist/Doctor ☐ Personal Records/ Moving ☐ Changing Physicians

☐ Other: ____

I understand that Pediatric Ophthalmology Associates will provide this information within 15 business days after date of receipt of the written consent for release and that a reasonable fee for furnishing this information may be charged.

Patient or Guardian: ______________________ Relationship to Child: ____________

Phone:______________________ Address: ______________________________

Signature: ______________________________ Date: ______________