njretina
An affiliate of PRISM Vision Group

# MEDICAL RECORDS RELEASE FORM

To: _____

Address: _____

Phone: _____

Fax: _____

Please release my medical records to:

Physician Name: _____

Mailing Address: _____

_____

Phone Number: _____

I authorize the release of my medical records or other health care information, including intake forms, chart notes, reports, correspondence, and other written information concerning my health and treatment during the period of

_____ to _____

_____ _____

Print Name Signature

_____ _____

Date of Birth Date