Fogg Remington EyeCare

Medical Records Release Form

Patient Name: _____ **Today's Date:** _____

Date of Birth: _____ **Contact Phone#:** _____

I authorize Fogg Remington EyeCare to release my Medical Records to:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ FAX: _____

Information to be sent:

☐ Office Notes – Date(s)_____

☐ Labs/Letters – Dates(s)_____

☐ Photos/Op Reports – Date(s)_____

☐ Other_____

Reason for Release of Medical Records (please check one):

☐ Continuing Care ☐ Insurance Change ☐ Moving Out of the Area ☐ Personal Use

I am aware there will be a fee of $10.00 charged to my account for my Medical Records.

_____ (please initial)

Patient Signature: _____ Date: _____

Relationship if Other Than Patient: _____

FRE FAX#: (559) 241-0257

NOTE: AUTHORIZATION REMAINS IN EFFECT FOR ONE (1) YEAR UNLESS OTHERWISE STATED OR CANCELLED IN WRITING

Records were: ☐ Mailed ☐ FAXed ☐ Picked Up Date: _____ Staff Initials: _____

Fee Paid: $_____ Staff Initials: _____ Date: _____

07/21