Authorization for Release of Medical and/or Ophthalmic Records

Please complete the following information:

Patient's Name_____ Date of Birth_____

Address_____

City, State, Zip_____

I request and authorize _____ to

release all Medical and/or Ophthalmic records of the patient named above to:

English Rows Eye Care
3027 English Rows Ave., Suite 209
Naperville, IL 60564
Phone: 630-922-2661
FAX: 630-470-6979

This request and authorization includes, but is not limited to:

- All examination and progress notes, including prescribed medications.
- All current and previous glasses and contact lens specifications.
- Any diagnosis, treatment, prognosis, recommendation and other pertinent data.
- Other (specify) _____

I HEREBY AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS AS PROVIDED ABOVE.

_____ _____ _____
Signature Date Print Name

IF INDIVIDUAL IS UNABLE TO SIGN THIS AUTHORIZATION, PLEASE COMPLETE THE INFORMATION BELOW

_____ _____ _____
Name of Guardian/Representative Legal Relationship Date

NOTE: This Authorization does not extend to HIV test results, outpatient psychotherapy notes, drug or alcohol treatment records that are protected by federal law, or mental health records that are protected by the Lanterman-Petris-Short Act.