

**THE EYE DEPOT**  
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PERMISSION FOR  
RELEASE OF MEDICAL RECORDS

PATIENT: \_\_\_\_\_ CHART#: \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_ SOCIAL SECURITY#: \_\_\_\_\_

OFFICE SENDING RECORDS: \_\_\_\_\_

Physician's Name

Address

City

State

Zip

I hereby request that my medical records be released to:

OFFICE RECEIVING RECORDS: \_\_\_\_\_

Physician's Name

Address

City

State

Zip

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Signature of Physician Requesting Records

\_\_\_\_\_  
Date