



MEDICAL RECORDS RELEASE

Patient Information

Patient Name: _____ Date of Birth: _____ Phone #: _____

Address: _____ Email: _____

Information Requested From

New Perspective Eye Care at Formica Optical
110 Revco Rd, Somerset, PA 15501

Phone: 814-443-6508 Fax: 814-443-0590 Email: info@newpeye.com

Send Information To

Name: _____

Send Information By: Mail Fax Email Phone

Address: _____

Phone #: _____ Fax #: _____ Email: _____

Specification of information to send: _____

I, _____ (name), hereby grant permission for you to release confidential health information about me, by releasing a copy of my medical record, or a summary or narrative of my protected health information to the physician/facility/entity listed above.

Patient Name (PLEASE PRINT)

Date

Patient Signature