NEW PERSPECTIVE
EYE CARE

MEDICAL RECORDS RELEASE

Patient Information

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

Address: _____ Email:_____

Information Requested From

Name: _____

Address: _____

Phone #: _____ Fax #: _____ Email: _____

Send Information To

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

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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