PERMISSION TO RELEASE PATIENT RECORDS

Allen Eye Associates, P.A.
690 S. Watters Road
Allen, TX 75013
(972) 727-6262 Fax: (972) 727-2120

Date: _____

Patient's name: _____

I grant permission for (please include fax #):_____

to release my patient records to:

Allen Eye Associates
Jay Lollar O.D.
John Wimbish O.D.
Montgomery Vickers, O.D.

The medical findings and treatment disclosed should cover the period of time from

_____ to _____

In initializing this request, I hereby release my practitioner from any laws governing the disclosure of confidential or privileged information.

_____
Signature of patient

Or

_____
Signature of authorized representative