

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: _____

Date of Birth: _____

Social Security Number: _____

Please provide a copy of my medical records as indicated below:

_____ Complete record

_____ Records of care from _____ to _____ only

_____ Records of care concerning the following condition(s):

- _____

To the following person(s):

Name

Street

City, State, Zip

For the purpose of continuation of medical care.

Signature of Patient or Legally Authorized Representative

Relationship to Patient

Date

Please return to: Associated Eye Care, Inc.
Attn: Medical Records
1000 Regency Court
Suite 100
Toledo, OH 43623