

RELEASE OF MEDICAL RECORDS

To: _____

From: _____

(Patient's name)

This is to request that you release copies of the above named patient's medical records, registration forms, correspondence and materials pertinent to the patient's care. Include all photographs and visual fields, if any. Please send this information to:

Glaucoma Associates of Texas

7150 Greenville Avenue, Suite 300

Dallas, Texas 75231

Signed: _____

(Signature of patient or person responsible for patient)

(Relationship)

(Date)