

RELEASE OF MEDICAL RECORDS

ADDRESS: DATE OF BIRTH:	DATE:
DATE OF BIRTH: I hereby authorize Mountain Eye Associates, PLLC to release my entire medical record to:	PATIENT NAME:
DATE OF BIRTH:	ADDRESS:
I hereby authorize Mountain Eye Associates, PLLC to release my entire medical record to:	
I hereby authorize Mountain Eye Associates, PLLC to release my entire medical record to:	DATE OF BIRTH:
	I hereby authorize Mountain Eye Associates, PLLC to release my entire medical record to:
Patient or Legal Guardian Signature:	
	Patient or Legal Guardian Signature:
Witness Cignotypes	Witness Signature:

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