Medical Records Release Form

To: _____

_____

_____

Eye Consultants of Colorado
10791 Kitty Drive; Suite B
Conifer, CO 8033
Fax: 303.816.7218

Patient Name: _____

DOB: _____/_____/_____

☐ This patient has come to our office for their eye care and vision needs. At the patients request, please forward all of their medical records, including a complete contact lens prescription (if relevant) to our office.

☐ This patient is transferring their care to your office for their eye care and vision needs. At the patients request, their medical records are being transferred to your office.

☐ Note: We are specifically requesting the following information regarding this patient. Please forward the requested information at your earliest convenience.

I hereby grant the above named person(s)/medical facility permission to exchange information from my records.

_____ _____ _____
Signed Please print Last name, first name Date