ADVANCED FAMILY VISION CARE

Complete Family Eye Care and Optical
Vision Development and Rehabilitation Center
Michelle May, OD, FCOVD

REQUEST FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____

Date of Birth: _____

I give my permission for _____ to give my/my child's medical records (as described below) to Dr. Michelle May at Advanced Family Vision Care.

Requesting Records From

Name of Practice: _____
Name of Physician: _____
Fax Number: _____
Address: _____

Types of records being requested

□ any and all types of records you have for this patient

□ doctor visit notes
□ emergency room notes
□ urgent care notes
□ history & physical
□ hospital progress notes
□ operation or procedure notes
□ clinic notes
□ other _____

□ pathology reports
□ doctor's orders
□ nurses notes
□ discharge summary
□ lab reports
□ radiology reports
□ consultations

Dates of records being requested

□ All records for this patient

□ records dated between _____ and _____

Please send records to:

□ I would like my records released directly to me

□ please send my records to:
Attention: _____
Fax Number: _____
Or mail to: _____
_____
_____

Signature: _____ Date: _____

Name: _____ Relationship to patient: _____

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