Medical Records Release Form

Date: _____

Patient Name (print): _____

Date of Birth: _____(mm/dd/yyyy)

FACILITY TO RELEASE RECORDS: _____

FACILITY FAX NUMBER: _____

This is a request to have my **FULL RECORDS** sent including **ANY VISUAL FIELD TESTS** to:

Advanced Cataract & Glaucoma Care, PLLC

7515 State Road 52, Suite 104

Hudson, FL 34667

Phone: 727-300-0299

Fax: 727-249-0969

Sincerely,

X_____