RECORDS RELEASE/REQUEST

I, _____, Date of birth _____ hereby authorize

_____

(Doctor/Hospital)

Address: _____

City: _____ State _____ Zip _____

Phone: _____ Fax: _____

to release my complete vision records or copies of such and request that they be transferred to:

CITY OF VISION EYE CARE
4025 Jackie Rd. SE
Rio Rancho, NM 87124
Phone: (505) 892-8411
Fax: (505) 891-5497
Email: cov@swcp.com

Please include records for:

Myself_____DOB_____
PRINTED NAME OF PATIENT

My spouse_____DOB_____
PRINTED NAME OF PATIENT

My minor child_____DOB_____
PRINTED NAME OF PATIENT

My minor child_____DOB_____
PRINTED NAME OF PATIENT

My minor child_____DOB_____
PRINTED NAME OF PATIENT

_____
Printed Name of Party Requesting Records if Patient is a Minor

_____
Patient/Responsible Party Signature Date

Requestor's contact information