CITY OF VISION
EYE CARE

Medical Record Request Form

Patient Information

First Name | Last Name | Date of Birth

Mobile Phone | Email

Medical Records From

Facility / Entity Name | Phone Number | Fax Number

Email

Medical Records To

Facility / Entity Name | Phone Number | Fax Number

Email

Request Details

Purpose of Request

- [ ] Personal Use
- [ ] Transfer of Care
- [ ] Legal Purposes
- [ ] 504 Plan
- [ ] Individualized Education Plan
- [ ] Correspondence with others involved in care
- [ ] Evaluation Results/Summaries
- [ ] Other

Addtional Notes:

Delivery Method

- ◯ Mail
- ◯ Fax
- ◯ Email
- ◯ Pick Up *Approximately $0.25/page

Authorization

I, the undersigned, authorize the release of my medical records to the specified individual or entity. I understand that this information may include sensitive and confidential details related to my health.

Signature | *Date:*