



# VISION SOURCE OF TEXARKANA

*Your Vision Care Specialists*

## Medical Record Release Request (Please print clearly)

### Step 1: Personal information

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

SSN: \_\_\_\_\_

### Step 2: Who has the records now?

I hereby authorize: Dr. \_\_\_\_\_; From the office of: \_\_\_\_\_

Phone # \_\_\_\_\_ Fax# \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

### Step 3: What records would you like released?

To release the following information:

Contact lens Rx

Spectacle Rx

All records

Other: \_\_\_\_\_

### Step 4: To whom do you wish to release your records?

To: Dr. \_\_\_\_\_; From the office of: \_\_\_\_\_

Phone # \_\_\_\_\_ Fax # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

I understand that without this authorization, the provider would not be permitted to disclose this information, as indicated by law. I further understand that this information will become part of my case history.

Thank you,

\_\_\_\_\_  
Patient or Legal Guardian Signature

Date \_\_\_\_\_