3383 W. Main St
Thatcher, AZ 85552
Phone: 928-792-4455
Fax: 928-792-4463

Medical Records Release Form

Date:_____

To:_____

Phone: ( )_____ Fax: ( )_____

Address:_____

City:_____ State:_____ Zip:_____

I hereby authorize you to release to:

Elite Eyecare Center PLLC
3383 W Main St, Thatcher AZ 85552
Phone (928)792-4455
Fax (928)792-4463

_____*All information including diagnosis and records of any treatment or examination rendered to me*

_____Any information including diagnosis and records of any treatment or examination rendered to me during the last 2 years

Please include both Clinical and Surgical files where appropriate

Special Instructions/ Date of scheduled appointment:_____

_____

_____

Printed name:_____ Date of birth:_____

Signature:_____ Date:_____

_____ _____

Witness Printed Name Witness Signature