Records Request Form

Provider/Entity: _____

Address: _____

City / State / Zip: _____

Secure email: _____

FAX: _____

Information Requested:

I _____ (patient full name) authorize the above-named provider/entity to release the following designated medical information.

___ Copy of complete medical records including results of diagnostic testing

___ Copy of contact lens prescription

___ Copy of spectacle lens prescription

___ Other information_____

RELEASE AUTHORIZED TO
Prchal & Prchal PC
2809 Old Dawson Rd.
Albany, GA, 31707

Secure email: _____

FAX:

I HAVE READ AND UNDERSTAND THIS FORM. I VOLUNTARILY AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

_____ Date _____ / _____ / _____
Patient or legally authorized individual signature

_____
Printed name if signed on behalf of the patient Designate parent or guardian