



## RELEASE OF MEDICAL RECORDS

DATE: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

I hereby authorize Mountain Eye Associates, PLLC to release my entire medical record to:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

Witness Signature: \_\_\_\_\_

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