Children's Eye Physicians

Kids' vision is our mission

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RELEASE OF INFORMATION-SHORT FORM
(Inspect and Copy Request Form)

TODAY'S DATE:_____

PATIENT'S NAME:_____ **DATE OF BIRTH:**_____

DESCRIPTION OF INFORMATION BEING REQUESTED (eg: medical records):_____

_____

_____

PLEASE SEND THE INFORMATION TO (include name and address): _____

_____

ATTENTION TO:_____

REQUESTED BY (NAME):_____ **RELATIONSHIP TO PATIENT:**_____

SIGNATURE:_____ **DATE:**_____

FOR OFFICE USE ONLY:

_____ **REQUEST ACCEPTED. DATE INFORMATION GIVEN/SENT:** _____

_____ **REQUEST DENIED. REASON:** _____

ACCEPTED/DENIED BY:_____ **TITLE:**_____

SIGNATURE: _____ **DATE:**_____