BLOOMFIELD
EYE ASSOCIATES
An affiliate of PRISM Vision Group

MEDICAL RECORDS RELEASE FORM

To: ____

Address: ____

Phone: ____

Fax: ____

Please release my medical records to:

Physician Name: ____

Mailing Address: ____

____

Phone Number: ____

I authorize the release of my medical records or other health care information, including intake forms, chart notes, reports, correspondence, and other written information concerning my health and treatment during the period of

____ to ____.

______________________________	______________________________
Print Name	Signature
______________________________	______________________________
Date of Birth	Date