EYE CARE SPECIALISTS OF

OKLAHOMA

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RELEASE OF INFORMATION

Patient Name: _____ **DOB:** _____ / _____ / _____

I do hereby request my medical records as instructed below:

☐ Full records as kept by this office: _____

☐ My records for the time period _____ / _____ / _____ to _____ / _____ / _____

☐ A specific section of my medical records, as follows: _____

_____

_____

Please mail or fax all records to the address or fax number listed above. We appreciate your cooperation and thank you for your prompt response.

X: _____ **Date:** _____ / _____ / ____