

Insight Laser & Cataract Eye Specialists

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REQUEST FOR RELEASE OF PATIENT RECORDS

The undersigned acknowledges their lawful authority to request the release of a patient's record. The undersigned and listed patient has hereby requested the transfer of said records and we hereby request that you release the following patient records.

PATIENT NAME: _____

DATE OF BIRTH: _____

COMMENTS: _____

PATIENT SIGNATURE _____ **Date:** _____

GUARDIAN SIGNATURE _____ **Date:** _____
(if applicable)

PLEASE FAX OR MAIL RECORDS TO: _____

THIS MESSAGE IS INTENDED ONLY FOR THE USE OF THE INDIVIDUAL OR ENTITY TO WHICH IT IS ADDRESSED AND MAY CONTAIN INFORMATION THAT IS PRIVILEGED AND CONFIDENTIAL AND IS EXEMPT FROM DISCLOSURE UNDER APPLICABLE LAW. IF THE READER OF THIS MESSAGE IS NOT THE INTENDED RECIPIENT, YOU ARE HEREBY NOTIFIED THAT ANY DISSEMINATION, DISTRIBUTION OR COPYING OF THIS COMMUNICATION IS STRICTLY PROHIBITED. IF YOU HAVE RECEIVED THIS COMMUNICATION IN ERROR, PLEASE NOTIFY US IMMEDIATELY BY TELEPHONE AND RETURN THE MESSAGE AT THE ABOVE ADDRESS VIA THE US POSTAL SERVICE: THANK YOU!