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)

PLASE FAX OR MAIL RECORDS TO: _____

_____

_____