Patient Release of Medical Records Form

Patient's Name:_____________________ request and give my permission to release my Medical Records for

the time period dating from_____________ to ____________ from the following

Medical Clinic:

Name:____
Address:____
City_______________________State___________zip_____
Phone Number:____________________________________
Fax Number:_______________________________________
Comments____
____

The Medical Records as listed above are to be released to:
Ophthalmology Consultants
Dr. Albert Lin, M.D.
9999 Bellaire Blvd Suite 760
Houston, TX 77036
Office Phone (832)767-5877
Office Fax (832)767-5964

______________________________	______________________________
Printed Patient Name	**Date of Birth**
______________________________	______________________________
Patient’s Signature	**Today's Date**