Medical Records Request

Provider/Entity:_____

Address:_____

City/State/Zip:_____

Secure email/Fax Number:_____

Information Requested:

I _____(patient full name) authorize the above-named provider/entity to release the following designated medical information.

_____Copy of complete medical records including results of diagnostic testing

_____Copy of contact lens prescription

_____Copy of spectacle lens prescription

_____Other information: _____

Release Authorized to:

Mountain View Vision

7435 Sisters Grove, Suite 210

Colorado Springs, CO, 80923

Fax: 719-380-5656

Secure email: info@mtviewvision.com

I HAVE READ AND UNDERSTAND THIS FORM. I VOLUNTARILY AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM. IF I AM SIGNING FOR A MINOR, MY SIGNATURE ATTESTS THAT I HAVE LEGAL AUTHORITY OVER MEDICAL DECISIONS FOR THE DESIGNATED MINOR.

_____

Print Name/Date of Birth (unless signing for minor)

_____Date_____/_____/_____

Patient or legally authorized individual signature

_____

Printed name if signed on behalf of the patient, designate, parent or guardian/date of birth of minor (if signing for minor)