Suburban Eye Care, P.C.

Eye care for the way you live today.. and tomorrow

Vision Therapy Center ◆ Low Vision of Michigan

From the Office of:
+ Dr. John P. Jacobi, OD, FCOVD
+ Dr. Brett R. Arnold, OD
+ Dr. Kayla K. Smith, OD

Medical Records Release Form

I hereby request Suburban Eye Care, P.C. to release any information including my diagnosis, records of my treatment or any examination rendered to me during the time period of _____ to _____.

I request my records be obtained by the following chosen method:

o By email to: _____

o By fax to: _____

o By mail to the address below

o Accessed through my patient portal

Patient Name: _____

Date of Birth : _____

Patient Address: _____

Patient Phone Number: _____

Guardian Name: _____

Patient/Guardian Signature: _____ Date: _____

FOR STAFF USE ONLY:

Date request received: _____ Staff Initials: _____

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