Park Cities
EYE ASSOCIATES

Cathy Ann Norton, O.D.
www.parkcitieseye.com

8115 Preston Rd., Suite 630
Dallas, Texas 75225
Office (214) 360-9951
Fax (214) 360-9819

REQUEST FOR MEDICAL RECORDS

TO:

Doctor / Office Name: _____

Address: _____

City/State/Zip: _____

Phone: _____

Fax: _____

I request that you release a copy of my medical records (including spectacle and contact lens prescriptions, photos, visual fields, or other test results, etc) directly to Cathy Ann Norton, O.D. at Park Cities Eye Associates.

Patient Name Printed: _____

Patient Date of Birth: _____

Patient Signature: _____

Date Signed: _____

Please fax my records to 214-360-9819. Please mail any color documents, such as fundus photos or corneal topography, to:
Park Cities Eye Associates
8115 Preston Rd, Ste 630
Dallas, TX 75225

Thank you in advance for your prompt attention to this request.