BASS LAKE FAMILY EYE CARE

Dr. Brad Weeks
Dr. Michelle Martin

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AUTHORIZATION TO RELEASE RECORDS

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Phone Number: _____

I request and authorize **BASS LAKE FAMILY EYE CARE** to release the records of the patient named above to:

Name: _____

Address: _____

PHONE: _____ FAX: _____

This request and authorization applies to:

☐ Records relating to the following treatment, condition, or dates: _____

_____

☐ All records

☐ Other: _____

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.