



**BASS LAKE
FAMILY EYE CARE**

Dr. Brad Weeks
Dr. Michelle Martin

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AUTHORIZATION TO RELEASE RECORDS

Patient Name/DOB _____

Patient Name/DOB _____

Patient Name/DOB _____

Patient Name/DOB _____

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.