MEDICAL RECORD RELEASE AUTHORIZATION

ALLISONVILLE EYE CARE CENTER

10967 Allisonville Rd., Ste. 120

Fishers, IN 46038

Phone: (317) 577-0707 * Fax: (317) 577-1561

I hereby request the medical records of:

_____
_____
_____
_____
_____

This request authorizes the release of copies of any and all information from any medical records regarding my visual examination and history **including** all visual field examinations and any or all ocular photographs.

To From

☐ ☐ **Allisonville Eye Care Center**

10967 Allisonville Rd., Ste 120

Fishers, IN 46038

☐ ☐

_____
_____
_____
_____

Patient's Signature: _____

(Parent or guardian if under 18)

Date: _____