



RELEASE OF INFORMATION AUTHORIZATION

Patient's Name: _____

Date of Birth: ____/____/____

Please release my medical records:

TO:

FROM:

Alpine Vision Center

1844 West Pullman Rd.

Moscow, ID 83843

Phone: (208) 883-1800

Fax: (208) 883-1811

TO:

FROM:

Please release all records, including but not limited to: progress notes, operative notes, laboratory test results, diagnostic tests, and x-rays.

I HEREBY AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS AS PROVIDED ABOVE.

Patient or Guardian's Signature

Date