San Gabriel Eye Center

San Gabriel Eye Center
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Release of Medical Records Form

This instrument is to request and authorize release of medical records to

San Gabriel Eye Center.

FROM:			**Date:**	
COMPANY:				
ADDRESS:		**CITY**	**STATE**	**ZIP CODE**
PHONE:	**Area Code** ( )			
FAX:	**Area Code** ( )			

Patient Name:		***Date of Birth***	
Patient Signature			
Patient Address:		***City***	***State***	***Zip Code***
Reason For Transfer:			
Witness Signature:		***Date***	

This document is confidential in nature and should not be copied or published in any form. If you are not the intended recipient, please contact the phone number listed above for immediate retrieval.