

# San Gabriel Eye Center

**San Gabriel Eye Center**  
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## Release of Medical Records Form

**This instrument is to request and authorize San Gabriel Eye Center to release and send my medical records to:**

<b>TO:</b>		<b>Date:</b>		
<b>COMPANY:</b>				
<b>ADDRESS:</b>		<b>CITY</b>	<b>STATE</b>	<b>ZIP CODE</b>
<b>PHONE:</b>	Area Code (       )			
<b>FAX:</b>	Area Code (       )			
<b>Patient Name:</b>		<b>Date of Birth</b>		
<b>Patient Signature</b>				
<b>Patient Address:</b>		<b>City</b>	<b>State</b>	<b>Zip Code</b>
<b>Reason For Transfer:</b>				
<b>Witness Signature:</b>				<b>Date</b>

*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.*