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:

TO:			**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***	