Folsom Lake Eye Care
4364 Town Center Blvd
Suite 118
El Dorado Hills, CA 95762
Phone: 916-292-9226 | Fax: 916-292-9227 | Email: info@FLECedh.com

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RELEASE OF RECORDS REQUEST

DATE:___________________________

TO: ____

STREET ADDRESS: ____

CITY:__________________________ STATE: _________________________ ZIP:_________________

PHONE:_________________________

FAX: ___________________________

folsom lake
EYE CARE

I hereby authorize Folsom Lake Eye Care to obtain from the following (check all that apply):

__Past medical records

__Old prescriptions

I understand that my authorization will remain effective from the date of my signature, and that the information will be handled confidentially in compliance with all applicable federal laws.

I understand that I may see the information that is to be sent, and that I may revoke the authorization at any time by written, dated communication. I have read and understand the nature of this release.

___________________________________ Patient Name

___________________________________ Patient Signature (Patient, Parent, Guardian)

___________________________________ Patient's Date of Birth