Blumenstock
Family Eyecare
A MEMBER OF Vision Source

1501 Pine Lake Road Suite 1
Lincoln, Ne 68512
402-421-7773 : Phone
402-421-7859 : Fax

Permission To Release Patient Records

Name:
DOB:

Date:

I _____, grant permission to _____ to release my personal medical records to Blumenstock Family Eyecare. This includes all Optos, OCT, and any other information pertinent to my treatment while under the care of Blumenstock Family Eyecare. The medical findings and treatment disclosed should cover the period from_____to_____. In signing this request, I hereby release my practioner from any laws governing the disclosure of the confidential or privileged information.

_____
Signature of Patient or Legal Guardian

_____
Printed Name

Name of Facillity to Request Records From:

_____ _____
Name Phone

_____ _____
Address Fax