RELEASE OF INFORMATION AUTHORIZATION

Patient's Name: _____

Date of Birth: ____/____/____

Please release my medical records:

☐ TO:
☐ FROM:

Alpine Vision Center
1844 West Pullman Rd.
Moscow, ID 83843
Phone: (208) 883-1800
Fax: (208) 883-1811

☐ TO:
☐ FROM:

_____
_____
_____
_____
_____

Please release all records, including but not limited to: progress notes, operative notes, laboratory test results, diagnostic tests, and x-rays.

I HEREBY AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS AS PROVIDED ABOVE.

_____ _____

Patient or Guardian's Signature Date