Eyecare Center of Ken Caryl

11550 W. Meadows Dr. #F Littleton, CO 80127

PHONE: 303.973.6333 FAX: 303.948.8103

Patient Medical Records Release Authorization

Patient Name: _____

Patient DOB: _____/_____/_____

Patient Signature: _____

Date: _____/_____/_____

☐ **Release to Eyecare Center of Ken Caryl**

I hereby authorize the release of my medical records including test results, last intraocular pressure measurement, retinal imaging, and the most recent prescription information for glasses and contact lenses to Eyecare Center of Ken Caryl from the following:

Name of Clinic/Doctor: _____

Address: _____

Phone: (_____)_____Fax: (_____)_____

☐ **Release from Eyecare Center of Ken Caryl**

I hereby authorize the release of my medical records including test results, last intraocular pressure measurement, retinal imaging, and the most recent prescription information for glasses and contact lenses from Eyecare Center of Ken Caryl to the following:

Name of Clinic/Doctor: _____

Address: _____

Phone: (_____)_____Fax: (_____)_____