PATIENT REQUEST FOR RELEASE OF MEDICAL RECORDS

Request of: _____
Doctor's Name

_____
Doctor's Street Address

_____
City, State, Zip

_____
Telephone Number

_____
Fax Number

Patient Name: _____

Date of Birth: _____

Please send my medical records to the following doctor/medical facility:

Heartland Eye Consultants
9900 Nicholas St, Ste. 250
Omaha, NE 68114
P-402-493-6500
F-402-493-4370

___all Medical Records

___last exam

___fundus photos

___visual fields

Other_____

Special Instructions_____

_____

I hereby grant the above named person(s)/medical facility permission to send my records to Heartland Eye Consultants, LLC. Please include a copy of this request with the records.

_____ _____
Patient Signature If patient is minor Parent/Guardian

Date: _____