

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: _____