McNeel Eye Center
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AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient's Name: _____ Date of Birth: _____

Address: _____ Social Security #: _____

I request and authorize the release of my healthcare information from: _____
_____
_____

Doctor's Name: _____

This request and authorization applies to:

◉ Healthcare information relating to the following treatment, condition, or dates

_____

○ All healthcare information ○ Other

Definition: All medical records to include but not limited to:

- x-rays, CT scans, MRI, MRA, Carotid Ultrasound, angiograms, photographs
- patient demographics, insurance and medical history
- surgical records
- Diagnostic testing including laboratory studies

○ Yes ○ No I authorize the release of my medical records

○ Yes ○ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date signed: _____

Print and sign here if legal guardian: _____ Relationship _____