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Tel. (818) 265-2255
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Email: services@lugeneeye.com

RELEASE OF MEDICAL RECORDS AUTHORIZATION

RELEASE OF RECORDS FROM: ______________________________

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I HERE BY AUTHORIZE AND REQUEST YOU TO RELEASE COPY OF MY MEDICAL RECORDS TO:

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THE COMPLETE MEDICAL RECORDS IN YOUR POSSESSION CONCERNING MY SCREENING, ILLNESS AND/OR TREATMENT DURING THE PERIOD OF:

☐ ALL FROM THE LAST 2 YEARS

OR

FROM: ______________________ TO: ______________________

SIGNATURE: ______________________________

PRINT PATIENT'S NAME: ______________________________

PHONE: ______________________________

DATE OF BIRTH: ______________ SOCIAL SECURITY: ______________

ADDRESS: ______________________________

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