RECORDS RELEASE

Records from:

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ FAX: _____

I hereby authorize you to release medical records to **Cornea Associates of Texas at 10740 N Central Expwy Ste# 325 Dallas, Texas 75231 Phone (214) 692-0146 Fax (214) 692-8617 Attn: Medical Records Department.** All information including the diagnosis, test and records of any treatment or examination rendered to me during the period of

_____ to _____

Patient Name: _____

Address: _____

City, State, Zip: _____

Patient's Phone: _____ DOB: _____

*If last seen at Cornea Associates over 3 years ago, was patient seen under a different last name?
Yes ☐ No ☐ If checked yes, please print full previous name _____

_____ _____

Signature Date