CHEROKEE EYE GROUP

A MEMBER OF VISION SOURCE®

JOYCE M. NATIONS O.D., M.P.H, • LEIGHANN M. KURTH O.D.

Medical Records Release

Patient Information:

Full Name:	Phone:
Address 1:	DOB:
Address 2:	SSN#
City and State:	Zip:

Request Records From:	Send Records To:
Doctor/Clinic Name:	Doctor/Clinic Name:
Address 1:	Address 1:
Address 2:	Address 2 :
City, State, Zip:	City, State, Zip:
Phone:	Phone:
Fax:	Fax:

I understand that any cancellation or modifications of this authorization must be done in writing, and that I have a right to receive a copy of this authorization. A photocopy of this authorization shall be as effective and valid as the original.

I furthermore release all parties stated here within from any legal liability resulting from the release of this information, with the understanding that all parties involved will exercise appropriate safeguards while using this information.

Signature: _____ Date: _____
(Patient or Legal Guardian)

Witness: _____ Date: _____
(Staff Member)

Please send all medical records as soon as possible

The records are to be: Mailed _____ Picked Up _____ Faxed _____

Completed By: _____ Date: _____

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