Medical Record Release

Patient Name		**Date of Birth**	
Street Address	**City**	**State**	**Zip**
Phone Number	**Email**		

I, _____, hereby authorize Raymond Forehand OD & Associates LLC, dba: Site to See

(Check one or both as needed)

◯To release information to ◯To obtain information from

Name/Title		**Organization**	
Street Address	**City**	**State**	**Zip**
Phone Number	**Fax Number**		
Email: _____			

Reports requested:

◯Examination record ◯Retina imaging ◯Referral ◯Other_____

- By signing this authorization I understand that I have the right to revoke this authorization at any time, if I do so in writing, and address it to the institution named above. The revocation will not apply to any information already released as a result of this authorization.
- Raymond Forehand OD & Associates LLC, cannot prevent re-disclosure of your information by the person or organization who receives your record under this authorization. By signing this authorization, you release Raymond Forehand OD & Associates, LLC, from any and all liability resulting from a re-disclosure by the recipient.

By signing below, I am attesting that I have legal right to authorize the release of my/this patient's medical record(s).

_____ _____

Patient name (Print) Date

_____ _____

Signature of Patient/Guardian Relationship to patient