PERMISSION TO RELEASE PATIENT RECORDS

Sterling-Eyecare.com

8155 Piney River Ave, Ste 120, Littleton, CO 80125

Phone: (720) 453-1980

Fax: (720) 453-1981

Date: _____

Patient's Name: _____

Patient's Date of Birth: _____

I grant permission for (please include fax #):_____

to release my patient records to:

Sterling Eyecare
Andrea Griffin O.D.

The medical findings and treatment disclosed should cover the period of time from

_____ to _____

In initializing this request, I hereby release my practitioner from any laws governing the disclosure of confidential or privileged information.

_____

Signature of patient

Or

_____

Signature of authorized representative