Medical Records Release

Patient Name: ___________________________________ Date of Birth: ______________________

Patient Address: ____

Authorizes: __________________________ Release of Records To: ___________________________

__________________________ ___________________________

__________________________ ___________________________

Information to be Released:

- Complete Records
- Visual Fields
- Letters
- Dates to be Included _____________ to _____________
- Other ____

I authorize release of my medical records in accordance with the specifications listed above.
I understand written notice is necessary to cancel request.

Signature of Patient: ____________________________________ Date: ______________________

Signature of Witness: ___________________________________ Date: _______________________

Internal use

Signature of Doctor: _____________________________________ Date: _______________________

Account Balance: ___________________________

Peter M. Schmid, O.D. l William F. Wiley, M.D. l Shamik Bafna, M.D. l William W. McGann, O.D.
1155 State Route 303, Streetsboro, Ohio 44241 l Phone: 330-422-2020 l Fax: 330-422-0316