COFFMAN VISION CLINIC

See what you've been missing!

PATIENT RECORD RELEASE STATEMENT

PLEASE READ THE FOLLOWING CAREFULLY:

I authorize _____
(eye clinic or facility where you were previously seen)
to release medical information to Coffman Vision Clinic for necessary continuation of care for my family/dependents and me.

_____ __/__/__
Signature Date

Which information do you wish to release/view?

___Ophthalmology Records ___Physician Office Chart Notes __Other

Dates: From_____ through_____

_____ DOB: __/__/_____
Patients Printed Name

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