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Authorization For Release Of Medical Records

Patient information (please print):

Name: _____ Date of Birth: _____

Social Security number: _____

Address: _____

City: _____ State: _____

Zip code: _____ Phone: _____

Release my medical records from:

Office/hospital name: _____

Telephone: _____

Fax: _____

TO

**Enochs Eye Care, PLLC.
3575 Bridge Road, Suite 21
Suffolk, Va. 23435**

Please send medical records no later than: _____

- Please release a copy of all of my medical records, including but not limited to, progress notes, operative notes, laboratory results and diagnostic tests.

BY MY SIGNATURE I AUTHORIZE RELEASE OF MY MEDICAL RECORDS

Patient: _____ Date: _____