FAMILY EYE MEDICAL GROUP
4100 Long Beach Boulevard, #108
Long Beach, California 90807-2696
Tel: (562)426-3925; Fax: (562)595-7639

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Date:

I hereby authorize:

Current Medical Record Keeper:
Street Address:
Town, State, Zip Code:

Phone Number:
Fax Number:

To furnish full details of the medical care of:

Patient's Name:
Date of Birth:
Phone Number:

Please send records to:

New Medical Record Keeper:
Street Address:
Town, State, Zip Code:

Phone Number:
Fax Number:

____
Name

____
Signature

Relationship to Patient:

Witness (if applicable):