

# MORROBAY OPTOMETRY

## MEDICAL RECORDS RELEASE

To \_\_\_\_\_ Fax Number \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I hereby authorize and request that a copy of the medical records concerning my illness and/or treatment during the period from:

\_\_\_\_\_ to \_\_\_\_\_  Present  All records

be provided according to the instructions indicated below. In addition, please provide copies of the following, if any:

- Retinal or other photographs
- Visual Field tests

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please send copies of my medical records to the individual and address listed above.

*or*

Please send copies of my medical records to Morro Bay Optometry.

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Date faxed \_\_\_\_\_

\_\_\_\_\_  
Print name if parent or legal guardian

Staff initials \_\_\_\_\_

Dr. Tiffany Smart O.D.  
590 Harbor Street • Morro Bay, CA 93442 • P 805.772.1269 • F 805.772.2172  
www.MorroBayOptometry.com