SOUTH MICHIGAN OPHTHALMOLOGY

Records Release Form

Patient's Name: _____ Birth Date: _____

Patient's Address: _____

_____

_____

I hereby authorize the release of

- o ALL MEDICAL RECORDS
- o MEDICAL RECORDS FROM _____ THROUGH _____
- o SPECIFIC ITEMS FROM MY MEDICAL RECORDS (PLEASE LIST):

_____

or copies of such from:

Doctor/Practice Name: _____

Phone #: _____ Fax #: _____

Address: _____

_____

_____

and request that they be transferred to:

South Michigan Ophthalmology
Darren Hathaway, M.D.
Naiya Panchal, O.D.

830 W. Michigan Ave.
Marshall, MI 49068

269-781-9822 (Phone) * 269-781-9839 (Fax)

_____ _____

Patient Signature Date