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Medical Release Form

My signature below authorizes Central Eye Care, Ltd. physicians and medical personnel to release or request medical records.

☐ I wish to release records **from** Central Eye Care, Ltd to:

OR

☐ I wish to release records **to** Central Eye Care, Ltd from:

Dr./Clinic: _____

Address: _____

City, State, Zip: _____

Telephone: _____ Fax: _____

Concerning the care and treatment of: _____

(Please Print)

Date of Birth: _____

Relationship to patient: ☐ Self ☐ Spouse
☐ Parent ☐ Guardian

Records to be sent: ☐ All Records on File (incl. recent tests -OCT, Visual Field, etc.)
☐ Billing information

Following Specified Records Only: ☐ _____

Signature: _____ Date: _____

3030 SALT CREEK LANE SUITE 300
ARLINGTON HEIGHTS, ILLINOIS 60005
PHONE: 847-978-4535 FAX: 847-960-5378