Martinez Eye Associates
3412 Wrightsboro Road
Augusta, GA 30909
706-736-3937
Fax 706-736-3938

REQUEST FOR RELEASE OF PATIENT RECORDS

Patient Name_____**DOB**_____**Date**_____

Address:_____

Phone Number:_____

Release Medical Record To/From:_____

Address:_____

Phone Number:_____ **Fax Number:**_____

○ **ALL MEDICAL RECORDS**

○ **RECORDS FROM MOST RECENT VISIT**

I, _____, AUTHORIZE AND REQUEST MY RECORDS BE RELEASED TO _____ IN A TIMELY MANNER SUCH THAT MY CARE MAY CONTINUE IN AN UNINTERRUPTED MANNER. I UNDERSTAND THAT I HAVE A RIGHT TO MAKE SUCH A REQUEST AND THAT SUCH A REQUEST WILL REQUIRE MY SIGNATURE AUTHORIZATION. I UNDERSTAND THAT I MAY REVOKE THE AUTHORIZATION AT ANY TIME BY WRITTEN, DATED COMMUNICATION.

SIGNATURE:_____ **DATE:**_____

PLEASE FAX RECORDS TO MARTINEZ EYE ASSOCIATES: 706-736-3938