Ophthalmology Consultants
of Fort Wayne, P.C.

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Date: _____

To: _____

_____

_____

I hereby authorize and request that all information concerning the medical history, examinations, treatments, hospitalizations and/or surgery for the following patient(s) be released to **OPHTHALMOLOGY CONSULTANTS OF FORT WAYNE, P.C.,** 7232 Engle Road, Fort Wayne, Indiana 46804-2222

Patient Name (please print) _____ Date of Birth _____

Patient Name (please print) _____ Date of Birth _____

FOR THE PURPOSE OF: _____

Signed _____ Date _____

Relationship to Patient _____

Patient Address _____

City _____ State: _____ Zip _____

~ This release shall be effective for sixty (60) days and is subject to written revocation, except to the extent action has been taken in reliance on the authorization. ~

For Ophthalmology Consultants of Fort Wayne, P.C. use only . . .

Action Taken _____

Date: _____ By _____