PACIFIC EYE
Passion defines us. Vision unites us.

Records Release Authorization

Patient Name_____

DOB:_____ Phone number:_____

I, _____, hereby authorize and request you to release copies of my medical records for the periods of _____ to _____.

_____Send Pacific Eye records to another physician

_____Request records from another physician

_____Copies of my records for my personal use

Physician_____

Address_____

City/State_____ Zip_____

Phone_____ Fax_____

Send Records to:

_____	816 E Enos Dr Suite A Santa Maria, CA 93454	Ph: 805-346-1717 Fax: 805-346-1525
_____	3855 Broad Street Suite B San Luis Obispo, CA 93401	Ph: 805-545-8100 Fax: 805-545-8902
_____	931 Oak Park Blvd Suite 201 Pismo Beach, CA 93449	Ph: 805-473-6640 Fax: 805-473-5873
_____	220 Oak Hill Rd Paso Robles, CA 93446	Ph: 805-227-1477 Fax: 805-227-1479
_____	1111 Ocean Ave Suite 7 Lompoc, CA 93436	Ph: 805-735-3468 Fax: 805-735-6461
_____	Optical Concepts-230 E Betteravia Santa Maria, CA 93454	Ph: 805-925-2645 Fax: 805-925-6556

Patient's Signature_____Date_____

Parent/Guardian's Signature_____Date_____