Amy Gallegos OD

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AUTHORIZATION TO RELEASE HEALTHCARE RECORDS

Patient's Name: Date of Birth:

Previous Name:

Records to be released from:

Phone:

Fax:

- Please accept this letter as authorization to release all my medical records to Eye Logic the office of Dr. Amy Gallegos. In addition to the full medical record we are requesting all additional testing such as visual fields, topography, imaging and correspondence from other eye care professionals.

- Please accept this letter as authorization to release my prescriptions for glasses and/or contact lenses to Eye Logic the office of Dr. Amy Gallegos.

Patient Signature: _____ Date:_____