Southland Eye Associates, PC
19950 S. Governors Highway
Olympia Fields, IL 60461

RECORDS RELEASE CONSENT FORM

THIS REQUEST IS BEING SENT TO THE FOLLOWING DOCTOR/PRACTICE:

Doctors Name: _____

Practice Name: _____

Practice Address: _____

****

Patient Name_____ Date of Birth_____

If a Child: Parent or Guardian's Name _____

Patient Address _____ City _____

State _____ Zip _____ Phone: _____

MEDICAL RECORDS RELEASE CONSENT

1. I hereby grant permission to the doctor identified below to share my or my child's medical information with Southland Eye Associates, PC and its doctors.
2. I also hereby grant permission to have this information faxed, emailed, or mailed to ***Southland Eye Associates, PC***
3. Specific Records Requested? From Date: _____ To Date _____
   _____
   _____

SEND VIA:
Fax to: 708-481-4852
Email to: support@southlandeye.com
Mail to: Southland Eye Associates, PC 19950 Governors Hwy, Olympia Fields IL 60461

_____ _____ _____
Signature Date Phone

_____
Relationship to Patient

Please Fax to 708-481-4852, or email to support@southlandeye.com
19950 Governors Hwy Olympia Fields IL 60461