



GRAND RAPIDS OPHTHALMOLOGY

Eye Care | Surgery | Laser Correction

Medical Records Department

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RECORDS RELEASE

My signature below authorizes Grand Rapids Ophthalmology, physicians and medical records personnel to release or request medical records.

I wish to release records from Grand Rapids Ophthalmology to:

OR

I wish to release records to Grand Rapids Ophthalmology from:

Dr. / Clinic _____

Address _____

City / State / Zip _____

Telephone _____ Fax _____

Concerning the care and treatment of _____
(Please print)

Patient # _____ DOB _____

Relationship to patient: Self Spouse Parent Guardian

Records to be sent: All Records on File Billing Information

Following Specified Records Only _____

Dated _____ Authorized Signature _____

Dated _____ Witness Signature _____