227 Eastern Avenue – Augusta, ME 04330 – Phone: 207-622-3185 Fax: 207-622-5697

ATLEEGLEATON
EYE CARE

MEDICAL RECORDS RELEASE AUTHORIZATION

Patient Name: _____
Patient Address: _____
Date of Birth: _____
Patient Phone Number: _____
Patient Email: _____

I _____ , hereby authorize Atlee Gleaton Eye Care to release my medical information to the medical provider provided below.

MEDICAL PROVIDER INFORMATION

Provider Name: _____
Provider Address: _____
Provider Phone Number: _____
Please specify applicable dates of service: _____

MEDICAL INFORMATION TO BE RELEASED

- ☐ Office notes/treatment
- ☐ Operative report
- ☐ Contact lens records
- ☐ Specialty testing (visual fields, OCT, HRT, GDx, photos, Fluorescein angiography)
- ☐ Other: _____

Authorization is effective until: _____(date not to exceed one (1) year).

Signature of Patient or Authorized Representative

_____

Relationship: _____

Date: _____