PATIENT MEDICAL RELEASE

SJ Vision Eye Care/Dr. Sujey Kuan
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Palm Harbor Fl, 34684
727-430-9359
www.sjvision.us

Must be filled completely

PATIENT NAME: _____

PATIENT DATE OF BIRTH: _____

PATIENT PHONE NUMBER: _____

PATIENT SIGNATURE: _____

IF MINOR,
NAME AND SIGNATURE OF LEGAL GUARDIAN: _____

I hereby authorize the release of all information in my patient file, including examinations, treatments, prescriptions and any other medical findings. In initiating this request, I hereby release my practitioner form any laws governing the disclosure of confidential or privileged information.

_____ Release entire record

_____ Release glasses/contact lens prescription only

Please send my records to: