Medical Records Release

PATIENT NAME: _____ PATIENT DOB: _____

❑ Dunbar Eye is requesting records on this patient:

FROM:	**TO:** **Dunbar Eye Associates** 1 Stewart Plaza, Dunbar, WV 25064 PHONE: (304) 768-3332 FAX: **(304) 768-5115**
ADDRESS:	
PHONE:	
FAX:	

❑ Patient requests records from Dunbar Eye Associates:

FROM: **Dunbar Eye Associates**	**TO:**
	ADDRESS:
	PHONE:
	FAX:

Information to release:

❑ Spectacle lens prescription
❑ Contact lens prescription
❑ Last exam record
❑ Complete medical records*
❑ Other:

Method of release:

❑ Upload to patient portal
❑ Fax to number listed above
❑ Print for patient pick up
❑ Mail to address above

* A $10 research fee applies for complete medical records requests to be printed or faxed.

I have read and understand this form. I voluntarily authorize the disclosure of my health information as described in this form. If I am signing for a minor child, I attest I have legal authority to make medical designations for the designated minor.

_____ _____
Patient or legally authorized individual signature Date

_____ _____
Printed name if signed on behalf of the patient Signer DOB

❑ parent ❑ guardian