PACIFIC EYE CARE CENTER
1270 Arroyo Way, Walnut Creek, CA 94596
Phone:(925) 945-8188 **Fax:**(925) 945-0360
Website: www.pacificeyecarecenter.org

RECORDS RELEASE AUTHORIZATION

Patient Name:_____ **Date of Birth:**_____

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Primary Phone:_____ **Secondary Phone:**_____

Please select one of the following options:

- ☐ I am requesting the release of all medical records. I understand that up to a $25.00 fee is due before a copy of my records can be released and will make payment arrangements accordingly.
- ☐ I would like one chart note from a specific visit. I understand there is no charge for this. The chart note I am requesting is for: (please list date, description of visit or a specific test result)

  _____

I am hereby authorizing and requesting that Pacific Eye Care Center release my medical records to:

- □ Myself – I will take the records with me or pick them up on:_____
- □ My doctor: Name:_____ Office Name:_____
  Address:_____ City:_____ State:____ Zip:_____
  Phone:_____ Fax:_____
- □ Other: Please list name of person picking up or fax number/address to send records to:

  _____

  _____

Patient/Guardian Signature:_____ **Date:**_____

Witness Signature:_____ **Print Name:**_____