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

RECORDS REQUEST AUTHORIZATION

To: Doctor's Name:_____**Office Name:**_____

Address: _____**Phone:** _____

_____**Fax:**_____

To Whom It May Concern;

I am hereby authorizing and requesting you to release my medical records to the doctors at Pacific Eye Care Center. Please fax the information to them at 925-945-0360 at your earliest convenience. *If there are more than 10 pages, please MAIL the information to the address listed above.* Thank you.

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

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

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

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

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