



## Authorization for Release of Prescription Records

\_\_\_\_\_  
DATE

I authorize the following protected health information to be released from the prescription record of:

\_\_\_\_\_  
LAST NAME (PLEASE PRINT)

\_\_\_\_\_  
FIRST NAME (PLEASE PRINT)

\_\_\_\_\_  
DATE OF BIRTH

\_\_\_\_\_  
ADDRESS

\_\_\_\_\_  
CITY

\_\_\_\_\_  
STATE / ZIP CODE

\_\_\_\_\_  
PHONE NUMBER

\_\_\_\_\_  
EMAIL ADDRESS

Requested Date(s) of prescription profile:  
\_\_\_\_\_

NOTE: If specific dates to be released are not indicated, all records will be released.

**Release Records From:**

**Release Records To:**

**Family Eye Care  
of Maryland Heights**

2311 McKelvey Rd.  
St. Louis, MO 63043  
Office: 314-434-9450  
Fax: 314-434-0151

Email:  
Familyeyecaremh@gmail.com

If same as above  
OR

NAME / ORGANIZATION: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

- Please call when my records are ready for pick-up
- Please fax my records to \_\_\_\_\_.
- Please email my records to \_\_\_\_\_.

\_\_\_\_\_  
SIGNATURE OF PATIENT (OF IF LEGAL REPRESENTATIVE –STATE AUTHORITY TO ACT)

\_\_\_\_\_  
DATE

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