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 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

Release Records From:

❑ 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