



## 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](mailto: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

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