Date: _____

MEDICAL RECORDS RELEASE FORM

MEDICAL RECORDS ARE BEING REQUESTED FROM:

_____

_____

_____

PATIENTS NAME: _____

PATIENTS DOB: _____

PATIENT/GUARDIANS SIGNATURE: _____

PLEASE RELEASE MY RECORDS TO:

BLINK EYE CARE AND EYE WEAR
16618 RIVERSTONE WAY, CHARLOTTE NC 28277
PHONE: 704-817-3800
FAX: 980-422-0380

____ DR. TRACY MACINTYRE, OD

____ DR. CHARLENE HENDERSON, OD

____ DR. CAITLIN RUSTEMEYER, OD