Patient Release of Medical Records Form

Patient's Name:_____ request and give my permission to release my Medical Records for the time period dating

from_____ to _____ from the following

Medical Clinic:

Name:_____

Address:_____

City_____State_____zip_____

Phone Number:_____

Fax Number:_____

Comments:_____

_____

_____

The Medical Records as listed above are to be released to:
Ophthalmology Consultants
Dr. Albert Lin, M.D.
6671 Southwest Freeway Suite110
Houston, TX 77074
Office Phone (832)767-5877
Office Fax (832)767-5964

_____ _____
Printed Patient Name **Date of Birth**

_____ _____
Patient's Signature **Today's Date**