AUTHORIZATION TO RELEASE RECORDS

I authorize: Lewisville Eye Care
Bindi A. Desai, OD
190 E. Round Grove Road
Lewisville, TX 75067

Phone: (469)549-0987 Fax:

to release copies of my medical records to : _____
Name of Business

_____
Address

_____
City State Zip

Patient's Name: _____ Date Of Birth: ___/___/_____

Patient's Address_____
Address

_____
Address

_____
City State Zip

Date of Request: _____

_____
PATIENT SIGNATURE

_____
WITNESS

Notes:_____
_____
_____
_____