EYEcare EYEwear Center, P.C.

WALTER R. GUSS, II O.D.
Comprehensive Eyecare
and Contact Lenses

Medical Records Release Form

I Hereby authorize: _____

_____

_____

to release the following information from the health record(s) of :

Patient name : _____

Address: _____

Date of Birth: _____ **Social Security Number:** _____

Covering the period of treatment:

From: _____

To: _____

The information is to be released to:

_____

_____

_____

_____ _____

Patient Signature **Date**

_____ _____

Witness Signature **Date**

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EyeCareEyeWearCenter.com