Shawnee Vision Source®

REQUEST FOR RELEASE OF MEDICAL RECORDS

100 East 45th Street

Shawnee, OK 74804

Phone (405) 275-7676

Fax (405) 275-6837

Patient's Name:_____

Patient's date of birth:_____

Patient's SS#:_____

☐ I hereby authorize the release of my Medical Records from the above named practice to:

☐ I hereby authorize the release of my Medical Records to the above named practice from

Company/Individual Name:_____

Address:_____

City:_____

State:_____

Zip:_____

Phone Number:_____

Fax Number:_____

Email Address: _____

I have the right to revoke this request in writing at any time, except to the extent that action has already been taken to comply with it. Unless revoked, this authorization will remain valid until the disclosure indicated above has been satisfied.

The information being requested is privileged and confidential. It is intended for the individual or entity designated. I am hereby notified that dissemination, distribution, copying, or other use of this information by anyone other than the recipient designated is unauthorized and strictly prohibited.

_____ _____

Patient (or legal guardian) Signature **Date**