HOLLAND EYE SURGERY & LASER CENTER

Release of Medical Records From Holland Eye Surgery & Laser Center

Patient Name: _____ Date of Birth: _____
please print

Please release my medical records to: _____

_____

Phone: _____

Fax: _____

Reason for medical record release:

- □ Second Opinion
- □ Moving out of the area
- □ Returning to original provider
- □ Dissatisfied with eye care provider/practice
- □ Other: _____

_____ _____
Patient Signature ***Witness***

_____
Date

Date records sent: _____ Signature: _____

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