EYE HEALTH PROFESSIONALS, P.C.

JOHN W. REDMOND, M.D.

CATARACT SURGERY
GLAUCOMA TREATMENT
DRY EYE THERAPY

COSMETIC EYELID SURGERY
BOTOX INJECTIONS
LASER SKIN REJUVENATION

MEDICAL RECORDS RELEASE

1. If you want us to send your eye medical record to someone, print the name and address here.

Name _____

Address _____

State _____ Zip Code _____

Do you want us to send your full record or part of it? Check off below what you want sent.

_____ All Records _____ Current Contact Lens Prescription

_____ Office Visits _____ Current Glasses Prescription

_____ Test results _____ Other: Specify _____

2. If you want to use this form to give permission to some other practitioner to send your medical record to us, tell us who we should contact to obtain your records.

Name _____

Address _____

State _____ Zip Code _____ Phone # _____

****

Your Name _____ Date of birth _____

Address _____

State _____ Zip Code _____ Phone # _____

Your Signature gives permission as specified above:

_____ _____

Patient Signature Date

****

Office Use:

Reviewed by _____

John W. Redmond, MD Date

Special Instructions _____

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