DENVER VISION THERAPY

Developing Visual Excellence
Leanna Dudley, OD, FCOVD
Developmental Optometrist

Records Release

I give my permission to release my records, or the records of the following patients:

_____

Patient Name (Please Print) Maiden Name (if applicable) Date of Birth

_____

Patient Name (Please Print) Maiden Name (if applicable) Date of Birth

_____

Signature of Patient/ Responsible Party Date

Please Send My Medical Records **TO**:

Name: _____

*Address:*_____

*Address:*_____

*City/State/Zip:*_____

*Phone:*_____

*Fax:*_____

Please Obtain Records **FROM**:

Name: _____

*Address:*_____

*Address:*_____

*City/State/Zip:*_____

*Phone:*_____

*Fax:*_____

If you'd like to authorize another person to be able to obtain your medical information, such as a family member, spouse, etc.; please list their name(s) and sign below.

1._____

2._____

Signature:_____