BRIGHTON VISION CENTER

MEDICAL RECORDS RELEASE REQUEST

Patient Name: _____ D.O.B. _____

Patient Address: _____

_____

Patient Phone Number: ( ) _____ ( ) _____

Requested from: _____

Phone Number: ( ) _____ Fax: ( ) _____

Please release information to:

Brighton Vision Center
2305 Genoa Business Park Dr., Suite 250
Brighton, MI 48114
Fax: (810) 494-0127

Information to be released:

- ☐ Outpatient Notes
- ☐ All Ophthalmic Testing Done
- ☐ Laboratory Test
- ☐ Other / Specific _____

Purpose of release request:

- ☐ Patient request
- ☐ Continuation of Care / Consultation
- ☐ Insurance Claim / Disability / Worker's Comp
- ☐ Attorney
- ☐ Other _____

Doctor requesting information:

Ayad Farjo, M.D. Karin Sletten, M.D. Emily Schehlein, M.D. Nicholas Carducci, M.D.

Patient Signature: _____ Date: _____

AUTHORIZATIONS SIGNED BY A LEGAL REPRESENTATIVE MUST INCLUDE A COPY OF THE GUARDIANSHIP PAPERS OR POWER OF ATTORNEY.

Initial & Date Faxed 1st request _____ 2nd request_____ 3rd request_____