McChord Optomery
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McChord AFB, WA 98438-1304
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MEDICAL RECORDS RELEASE FORM

Date: _____

Patient Name: _____

Address: _____

City/State/Zip: _____

Phone: _____

Date of Birth: _____

SEND RECORD OUT	I request and authorize McChord Optometry to release information to: Provider or Organization:_____ Address:_____ City/State/Zip: _____ Phone: _____ Fax: _____
RECEIVE RECORD	I request and authorize the provider/clinic indicated below to release information to McChord Optometry: ◯ All Eye Records ◯ Date Range: _____ Provider or Organization:_____ Address:_____ City/State/Zip: _____ Phone: _____ Fax: _____

_____

Patient Signature Date