Professional Eyecare, LLC
Request for Medical Records

Patient requesting records:

First Name: _____ Last Name: _____ DOB: _____

Facility to release records:

_____

Please send a copy of my medical records to:

_____ Myself. My mailing address is:

_____

_____ Professional Eyecare, LLC (131 Boston Post Rd, Suite 4, Waterford, CT 06385, tel: 860-442-5058, fax: 860-443-4118)

Records requested:

_____ A reasonable period that adequately covers important issues in patient's care, as determined by a clinician in your practice

_____ From: _____ To: _____

_____ Complete medical record

_____ A summary of care letter dictated by a clinician in your practice

Certification:

I hereby request a copy of my medical records as described above.

Patient signature: _____ Date: _____

Guardian or Power of Attorney (if any): _____
Date: _____