Scott I. Morrison, O.D, F.A.A.O. · The Professional Center · 243 Main Street · Suite 120 · New Paltz, NY 12561 · (845) 255-4696
2294 Route 208, Suite 7 · Montgomery, NY 12549 · (845) 778-3591

Patient Self- Records Release

Date: ______________________

Patient Name: ____

Patient DOB: ________________

I hereby request that copies of my complete ophthalmic medical records. Which may include visual fields and photos be released to myself or legal guardian. If requesting records are to be sent to another provider or facility, receiving provider/facility may provide you with an authorization form in place of this document.

Please send records via the following method:

	Method	To
☐	Fax	#
☐	US Mail	Address:
☐	Hand Pickup	Hand pick up can only be released to authorized people

Authorized Signature: _________________________

Date: _______________________________________

INTERNAL USE ONLY

Date released:________________________________

Released by:_________________________________

Must be scanned into system when completed.