CHEYNE EYE CENTER

4000 E. Hwy 377 Granbury, TX 76049

Ph: 817-573-7153 info@cheyneeyecenter.com F: 817-573-5640

RECORDS RELEASE AUTHORIZATION

To: _____
(Physician/Clinic/Hospital)

_____
(Address)

_____
(City, State, Zip Code)

_____
(Telephone Number) (Fax)

I hereby request and authorize you to release the complete history records in your possession, concerning my eye examinations and/or treatment during the period from:

_____ to _____ OR ALL Records

Attention Dr: (please circle one)

Chris Cheyne, OD Robert Yeaman, OD Courtney Cheyne Cobbs, OD Nicole Stout, OD Lori Russo, OD

Fax: 817-573-5640 or Email: info@cheyneeyecenter.com

Name: _____ DOB: _____

Address: _____

_____

Signature: _____Date_____

Relationship to patient: Self Parent Legal Guardian Other: _____

Witness: _____Date_____