



RECORDS RELEASE/ TRANSFER REQUEST

DATE: _____

TO: _____
(doctor/hospital)

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

I HEREBY AUTHORIZE THE ___ RELEASE OR ___ REQUEST OF MY
RECORDS OR COPIES OF SUCH AND THAT THEY BE RELEASED OR
REQUESTED TO THE ABOVE INSTITUTION OR THE FOLLOWING DOCTORS:

_____ EDWARD WEAVER, Jr., O.D.

NAME OF PATIENT: _____

DATE OF BIRTH: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

SIGNATURE: _____
(patient, parent, or guardian)