Request for Release of Medical Information

Date of Request: _____

Re: Name and Address of Patient

_____

_____

_____

Patient's Date of Birth: _____

Send records to/from: Name and address of Recipient

_____

_____

_____

This authorization or photocopy hereof will authorize you to furnish all information you may have regarding my condition while under your observation or treatment, including the history obtained, x-ray and physical findings, diagnosis and prognosis to/from:

Vision Source of Amherst and Greenfield
Brian Wadman, O.D.
Melissa Morin, O.D.
Frederick Bloom, O.D.

_____ _____
Patient/Guardian Signature Date Signed

_____ _____
Witness Signature Date Signed

489 Bernardston Road
Greenfield, MA 01301
P: (413) 772-2571 F: (413) 772-2266

22 University Drive
Amherst, MA 01002
P: (413) 549-9400 F: (413) 549-0222