FAMILY eye care

Dr. William D. Gordon · Dr. Anthony Lamar · Dr. Melissa Polk
Phone : (318) 807-2020
Fax: (318) 388-1868

Records Release Authorization

Physician Name: _____

Address: _____

I hearby authorize and request you to release the complete medical records in your possession concerning my illness and/or treatment during the period of: _____

Patients, please complete information below.

Patient Name / Address: _____

_____

Patient DOB: _____/_____/_____ Patient SSN#: _____

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

Please send or fax records as soon as possible – medical treatment could be pending. Thank you.