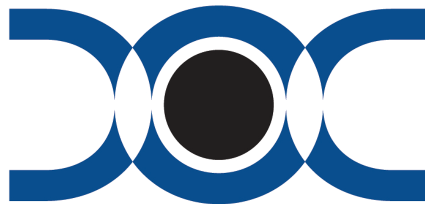

MEDICAL RECORDS RELEASE

Patient Name: ____

TO: **Delaware Ophthalmology Consultants**
(Please circle a location)

3509 Silverside Road-Talley Building
Wilmington, DE 19810
Fax # 302-477-2650

1941 Limestone Road- Suite 205
Wilmington, DE 19808
Fax # 302-477-2650

272 Carter Drive – Suite 100
Middletown, DE 19709
Fax # 302-477-2650

I hereby authorize copies of my medical records to be released to:
Name: ____
Address: ____
Fax:____

The documents I am requesting are: _______________________________

Please choose one of the following:
_____ I plan to return to Delaware Ophthalmology Consultants
_____ I do not plan to return to D.O.C. because:
____moving
____insurance
____other (please specify)______________________________

I understand that this request for release of information stands effective for 120 days and is limited to the above recipient only. This form requires the name of the patient to be printed and a signature by the patient or legal guardian. Please be aware that failure to complete all required sections of this form may delay your request.

___________________________ **___________________________**
Patient's Name (printed) **Patients Date of Birth**

_______________________________ **___________________________**
Patient's or Legal Guardian's Signature **Date**

For office use only: account #________________
Revised 11-14-19