Medical Record Release Form

Patient Name: _____ Date of Birth: _____

Address: _____

City, State, ZIP: _____

RECORDS TO BE RELEASED FROM:

Physician/Practice Name: _____

Physician/Practice Address: _____

Physician/Practice Phone Number: _____ Fax Number: _____

RECORDS TO BE RELEASED TO:

Physician/Practice Name: _____

Physician/Practice Address: _____

Physician/Practice Phone Number: _____ Fax Number: _____

PLEASE RELEASE THE FOLLOWING SELECTED:

□ Complete Records	□ Eye Exam	□ Nurse Notes	□ Operative Reports
□ Progress Notes	□ Physician Orders	□ Billing Notes	□ Doctor Notes
□ Discharge Summary	□ Test Results	□ Lab Reports	□ History & Physical

□ Other: _____

By signing this form, I consent and authorize you to release confidential health information about me by releasing a copy of my medical records to the physician/person/facility listed below.

_____ _____

Patient Signature ***Date***

O'Byrne Eye Clinic, LLC.

Mandeville Office
1580 W. Causeway Approach, Suite 3 Marilu O'Byrne, M.D.
Mandeville, LA 70471 Office: (985) 624-5573
Fax: (985) 624-9106

Slidell Office
2160 E. Gause Blvd. Ste 101
Slidell, LA 70461
Fax: (985) 639-8882