Jatinder Bansal, O.D.

B-TOWN EYECARE

Authorization to Release or Obtain Healthcare Information

Patient Name: _____ DOB: _____

Responsible Party: _____ Relationship to Patient: _____

Release Records **TO**:	Obtain Records **FROM**:
Physician/ Institution:	Physician/ Institution:
Address:	Address:
City, State, Zip:	City, State, Zip:
Phone:	Phone:
Fax:	Fax:

This request and authorization applies to (check all that apply):

( ) All health information:

_____

( ) Specific health information relating to the following treatment, condition or dates:

_____

( ) Other:

_____

_____ Date: _____

(Patient/ Parent/ Legal Representative Signature)

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