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Patient Records Release

Date:_____ Patient Name:_____

Patient D.O.B:_____

I hereby request that my medical records or copies of such be released:

From:

_____
Name

_____
Address

_____
City State Zip Code

_____
Phone number Fax

To:

Douglas J. Lavenburg, M.D., P.A.
DelMar Surgical Center, L.L.C.

Pleasecheckone:

____ I will be picking up my records
____ Please mail my records
____ Please fax my records

Reason for release:_____

_____
Patient's Signature Date

_____
Witness Signature Date

As a courtesy to our patients relocating out of the area, we will be happy to supply your new eye care provider a copy of your medical records at no charge. Any other requests for copies of medical records will be subject to a $25.00 administrative fee.

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