PATIENT RECORD RELEASE

Patient name _____Date of birth _____

Address_____

City _____State _____ Zip _____ Phone _____

Visionary Eye Center/Dr. Jason Bolenbaker
8175 South Virginia Street Suite B-900
Reno, Nevada 89511
775-827-1100 Fax 775-827-1138
Email drb@visionaryeyecenter.com

To: _____
Phone: _____
Fax: _____

I hereby grant release of my records to Visionary Eye Center.

Patient's signature _____Date _____
___ Parent/Guardian (if applicable)

Information requested: All records and/or _____

_____

_____

Glasses and/or contacts Rx Current only _____ Exp. For Records _____

**********Office Use Only**********

Records received _____. Reviewed by Dr. Bolenbaker on _____

No response as of _____. Addendum in chart by _____ on _____

Return to Clinic? YES NO

Notes: _____

_____

_____

Initials _____