

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 _____

THIS MESSAGE IS INTENDED ONLY FOR THE USE OF THE INDIVIDUAL OR ENTITY TO WHICH IT IS ADDRESSED, AND MAY CONTAIN INFORMATION THAT IS PRIVILEGED, CONFIDENTIAL AND EXEMPT FROM DISCLOSURE UNDER APPLICABLE LAW. IF THE READER OF THIS MESSAGE IS NOT THE INTENDED RECIPIENT, OR THE EMPLOYEE OR AGENT RESPONSIBLE FOR DELIVERING THE MESSAGE TO THE INTENDED RECIPIENT, YOU ARE HEREBY NOTIFIED THAT ANY DISSEMINATION, DISTRIBUTION OR COPYING OF THIS COMMUNICATION IS STRICTLY PROHIBITED. IF YOU HAVE RECEIVED THIS COMMUNICATION IN ERROR, PLEASE NOTIFY US IMMEDIATELY BY TELEPHONE, AND RETURN THE ORIGINAL MESSAGE TO US AT THE ABOVE ADDRESS VIA THE U.S. POSTAL SERVICE. THANK YOU.

*****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 _____