LAWRENCE EYE CARE ASSOCIATES, P.A.
1112 W. 6TH STREET, SUITE 214, LAWRENCE, KS 66044

REQUEST FOR MEDICAL RECORDS from:

_____
Physician or Hospital

_____

_____

_____

Medical Information to be released:

- ☐ Medical records **only**
- ☐ Include medical records/correspondence from other physicians
- ☐ Other

FOR DATES OF SERVICE FROM_____TO_____

_____

I hereby request a copy of my "Medical Records" be released to:

LAWRENCE EYE CARE ASSOCIATES, P.A.
1112 WEST 6TH STREET, SUITE 214
LAWRENCE, KS 66044
PHONE# 785-841-2280 FAX# 785-841-2765

_____ _____
Date Patient Signature

_____ _____
Patient Date of Birth Print Patient Name

_____ _____
Personal Representative Signature and Relationship to Patient Date

_____
Name/Address/Phone No. of Personal Representative of Patient