specs EYE CARE Casey N. Roland, OD

4409 Evans to Locks Road, Evans, GA 30809 • Phone (706) 396-7671 Fax (706) 396-7676

AUTHORIZATION FOR RECEIPT OF MEDICAL RECORDS

TO: _____

_____

RE:

PATIENT NAME: _____

ADDRESS: _____

DATE OF BIRTH: _____ **Last 4 of SSN:** _____

Specs Eye Care, PC is being authorized to receive medical information from the above noted party. This authorization includes reports of my diagnosis, treatment, prognosis and recommendations as well as other data pertinent to my treatment in relation to the medical necessity of my care. In addition, I am specifically requesting the following report(s) to be provided in addition to the above noted records:

_____

_____ _____

Patient Signature **Date of Request**

_____ _____

Witness Signature **Date of Request**

***THIS REQUEST EXPIRES 1 YEAR FROM THE DATE OF REQUEST**