Sun Eye Care, P.A.
1900 N. Oregon, Suite 209 • El Paso, Texas 79902
915.532.3697 • FAX 915.532.3506

CONSENT TO RELEASE MEDICAL RECORDS

I, _____, hereby request that Michael W. Foote, MD
(Patient Name / Legal Guardian)

☐ Be provided my medical records or correspondence from:
☐ Release my medical records or correspondence to:

_____ (Name of Doctor, Group, Hospital, Laboratory, Person)
_____ (Phone)

_____ (Street Address)
_____ (Fax)

_____ (City, State Zip Code)
_____ (E-mail or Web Address)

☐ Complete record
☐ Records of care from: _____ to _____
☐ Records of care concerning the following condition(s):_____
☐ Other: _____
☐ Confer orally with other personnel about information in my medical record

The reason(s) for the release of information is/are: _____

I consent to the release of any positive or negative test results for AIDS or HIV infection, antibodies to AIDS or infection with any causative agent of AIDS, with the rest of my medical records.
(Initials) _____ (Date) _____

AUTHORIZED THIS _____ DAY OF _____ 20____ BY:

_____ (Signature of Patient or Legal Guardian)
_____ (Social Security Number or Date of Birth)

_____ (Signature of Witness)
_____ (Date of Witness)

☐ Fee Waived (Reason) _____