2303 Osborne Dr. West, Hastings, NE 68901
281eyecare@gmail.com
402-834-2222 **FAX 402-834-3214**
Allo FAX 402-303-6680

Medical Release Form

I, ______________________________________ DOB _______________

Address: ____

City/State/Zip ____________________________ PHONE _____________

do hereby consent and authorize

_______________________________ FAX# ________________________

To release copies of my medical records to

281 Eye Care, Jennifer Deets, O.D.
2303 Osborne Dr. West
Hastings, NE 68901
FAX# 402-834-3214

Reason for request: ____

Other family members:

Patient Name ___________________________ Date of Birth __________

Patient Name ___________________________ Date of Birth __________

Patient Name ___________________________ Date of Birth __________

Patient Name ___________________________ Date of Birth __________

The above named individuals are entitled to receive information concerning my healthcare records as well as conduct business with 281 EyeCare/Jennifer Deets, O.D. regarding any and all dealings I may have with 281 EyeCare/ Jennifer Deets, O.D.. This agreement can only be cancelled in wrong and will not apply to any communication involving matters prior to its termination.

____ ________________
(Patient signature OR Guardian & relationship if under 18) Date

____ ________________
(Witness) Date