Sun Eye Care, P.A.

5920 Cromo Dr. | El Paso, Texas 79912
Phone: (915)532-3697 | Fax: (915)532-3506

CONSENT TO RELEASE MEDICAL RECORDS

Note: There is a $30.00 Medical Record Release Fee and will be collected at the time of pickup. Time limitation to provide medical records is 14 business days. We may transfer records to other physicians at no charge as a courtesy.

I, ____, DOB: _____________ hereby request that Michael W. Foote, MD and/or associated providers to Sun Eye Care, PA

◯ Be provided my medical records or correspondence from:

◯ Release my medical records or correspondence to:

____________________________________	____________________________________
(Name of Doctor, Group, Hospital, Laboratory, Person)	(Phone)
(Address)	(Fax)
(City, State, Zip Code)	(Email or Web Address)

◯ Complete Record

◯ Records of care from: ______ to ______

◯ Records of care concerning the following condition(s): _______________________________________

◯ Other: ____

◯ Discuss orally with other personnel about information in my medical record

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

I consent to 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)

$30.00Fee Collected: _________ Fee Waived (Reason) ____