611 N. Hudson St .
Silver City , NM 88061
Phone 575.538.2294
Fax 575.538.2996
www.eyecarenm.com

Consent for release of medical records

To: _____

_____

_____

_____

I, _____ hereby authorize you office or facility to provide all of my medical records (orally or written), pertaining to my medical history, services rendered, or any treatment at your office to Mountain View Eyecare.

_____
Patient Name

_____
Patient Date of Birth

_____
Last four numbers of SSN

_____ _____
Patient / Agent / Guardian Signature Date