DENVER
RETINA CENTER P.C.

Diana Reeves, M.D.

CONSENT TO RELEASE RECORDS

I HEREBY AUTHORIZE:

DENVER RETINA CENTER, P.C.
4500 Cherry Creek Drive South, Suite 102
Denver, CO 80246
PHONE: (303)-220-0393 FAX: (303)-740-5865

RELEASE MY MEDICAL RECORDS TO:

DOCTOR: _____

OFFICE: _____

ADDRESS: _____

PHONE: _____ FAX: _____

PATIENT INFORMATION:

NAME: _____

PARENT / LEGAL GUARDIAN: _____

(If patient is under 18 years of age)

DATE OF BIRTH: _____ PHONE: _____

SIGNATURE: _____

(Parent / Legal Guardian must sign if patient is under 18 years of age)

DATE: _____

ADDITIONAL NOTES: