FRIEDRICHS EYE

I authorize Friedrichs Eye to release

Patient's Name: _____

Date of Birth: _____ medical records to:

(Please check one of the two options.)

☐ **Physician**

Practice Name: _____

Street: _____

City: _____ State:_____ Zip _____

Phone Number: _____ Fax Number: _____

☐ **Myself**

Name: _____

Street: _____

City: _____ State:_____ Zip _____

☐ **I would like to have the records email to my email address:**

Email: _____

_____ _____

Patient Signature or Parent/Legal Guardian Date

Please email request to fe@friedrichseye.com or mail the request to PO Box 827 DeKalb, IL 60115

I understand that you will provide this information within 14 business days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Illinois State Board of Medical Examiners.