



Consent for Release of Records

I hereby give my permission for the **Bentz Eye Center** to release or obtain the following records and /or information for:

Patient Name _____

Date of Birth _____ Account# _____

All Records on File Service Dates _____ to _____

Request for release records to or from:

Fax Records Fax# _____ Mail Records Patient/Legal Guardian

Doctor/Facility Name _____

Address _____

City _____ State _____ Zip _____

Attention _____

Purpose of Release of Records _____

I understand that this consent can be withdrawn at any time except in the event that the requested records have not been released or obtained prior to revocation

This request expires No expiration date Date _____

Bentz Eye Center, its doctors and employees will not be held legally responsible or liable for fulfillment of this request as fore mentioned.

Signed _____ Date _____
Patient or Representative

Relationship to Patient Date _____

Witness Date _____